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REHABILITATION IN NEUROLOGIC DISORDERS*

Its Philosophy, Program, and Future

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THE principles of modern rehabilitation may be defined as a system of comprehensive therapeutics so designed as to bring the chronically disabled patient to the highest functional level of physical, psychological, social and vocational adjustment compatible with his disability. In a generic sense, however, modern rehabilitation embodies more than a comprehensive treatment program. It is a philosophy of total care developed as the result of medical handicaps sustained by thousands of disabled World War II veterans and by a mounting public demand for a sharper medical focus on the impact of chronic disease on the Nation's health and manpower potential. In brief, the modern rehabilitation movement presents an ideological challenge to the therapeutic defeatism underlying the time-honored programs of custodial care for chronic incurables.

Perhaps for no other category of patients do the concepts of modern rehabilitation have a wider application than for those afflicted with neurologic disorders. This group of patients, when considered in aggregate, comprise one of the largest masses of long-term cripples in the country—and it is a group in which therapeutic defeatism has run rampant. The size of the problem is reflected in the findings that neurologic patients comprise from 25 to 50 per cent of the bed population in hospital rehabilitation services, or in homes for custodial care.[1, 2]

Moreover, the principles of modern rehabilitation have a special application to neurologic disorders.[3] To begin with, the pathogenesis of most disabling neurologic disorders is still unknown; hence, there is no specific therapy, and therapeutic goals must be limited to maximum development of residual functions. Also, since the central nervous system controls the finer rhythms of motor, sensory, and intellectual performance, its disorders are often associated with crippling or socially unsightly clinical manifestations which impede refined social and interpersonal relations. The paralytic tries to hide his paralysis, the man with extrapyramidal disease endeavors to conceal his grotesque involuntary movements. The epileptic often denies his seizures, even though controlled, for the mere admission of a past history of seizures might jeopardize his chances to obtain or retain a job. This inclination on the part of many neurologic patients to view their disability with shame makes their rehabilitation a problem of retraining, not only on a purely physical level but on psychologic and socioeconomic levels as well. A neurologic rehabilitation program, therefore, embraces the rehabilitation of the "whole" man in its fullest meaning.

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* Delivered at the 24th Annual Scientific Assembly of The Medical Society of the District of Columbia, October 7, 1953.

Over-all Orientation

The effective rehabilitation of chronically disabled patients requires a therapeutic orientation which is somewhat different from established precepts of medical treatment, where major emphasis is placed upon particularized therapies for specific diseases or syndromes. Rehabilitation is not a cure but a compromise with cure until, and if, a definitive cure is found. Accordingly, the physician, engaged in rehabilitation, first adopts a medical philosophy of limited therapeutic objectives: to train the patient how best to live with his disabilities and how best to exploit fully his residual capacities. The acceptance by the physician of limited therapeutic objectives is particularly important in the rehabilitation of neurologic patients, for frequently damage to the central nervous system is permanent and lost functions must be compensated for by substitute mechanisms.

In addition, the physician primarily concerned with neurologic rehabilitation is equipped to evaluate realistically neurologic disabilities. To be so equipped, he must not only be versed in the standard neurologic examinations of the classical clinico-anatomic approach and its modern neurophysiologic supplements, but, also, he must be experienced in testing neuromuscular functions and activities of daily living as well as their potential for further development. A realistic evaluation of the residual functions of neurologic patients is of paramount importance to the rehabilitation process.

Finally, the physician primarily occupied with neurologic rehabilitation should possess the quality of leadership needed to organize a smoothly integrated therapeutic program. Rehabilitation in the most effective form requires a team approach—the team consisting of both medical and paramedical personnel. In the latter group are clinical psychologists, physical therapists, occupational therapists, speech therapists, social workers, vocational counselors, bracemakers, and others.

The two components of the therapeutic team, medical and paramedical, should function as a single action unit directed toward the maximum physical restoration of the patient and, equally essential, toward his social and vocational reintegration into family and community life. The physician and therapeutic team are integrated and function in such a way as to create an atmosphere highly charged with individual and group motivation. Motivation is a key therapeutic element in the rehabilitation of neurologic patients. It can be enhanced by stimulating a spirit of competition among the patients. Experience has shown that group motivation and a constructive competitive spirit is more effectively instilled and preserved if disabled neurologic patients are housed with patients suffering from similar disabilities and not intermingled with patients afflicted with disorders of different nature, such as cardiac or psychiatric cases.[3]

In summary, therefore, the medical and paramedical personnel of a neurologic rehabilitation team are oriented toward a therapeutic approach which extends far beyond the use of standard medical technics for the restoration of physical and mental deficits. This comprehensive approach, oriented as it is in the dynamics of patient motivation and in retraining methods for social and occupational adaptations, calls for a close working liaison of the therapeutic team with individuals and groups in the community and with local, state, and Federal agencies concerned with employment, vocational rehabilitation, and welfare for the handicapped.

RESULTS OF NEUROLOGIC REHABILITATION

To evaluate the results of rehabilitation of neurologic patients is not an easy task. Many important variables complicate the picture. Measuring limited therapeutic achievements often defies precision. Weighing the cost of rehabilitation against long-term economic gains can border on speculation. And the intense human values involved in rehabilitation are difficult to measure statistically.

It is claimed that many neurologists, knowing how easily the cells of the nervous system can be damaged beyond repair, incline toward skepticism.[4] It also is maintained that many physiatrists and rehabilitation groups, stimulated by the exuberance of a fresh movement, incline toward an undue optimism.[5] The truth probably lies in between.

Baker and Brown[6] have demonstrated that 75 per cent of a large group of veteran patients in all neurologic categories, who had been hospitalized from 3 to 20 years, could be discharged to their homes in varying degrees of readjustment, ranging from gainful employment to a life of independent self-care at home. Similar results have been reported from other Veterans Administration programs.

In a follow-up study of 208 chronic patients, a large segment of which were neurologic cases, Rusk[7] reports that 90 per cent derived some benefit from a rehabilitation program. Of this group the number confined to wheel chairs and beds decreased from 67.8 per cent to 32.2 per cent of the total, and the number of bedfast decreased from 31.1 per cent to 19.1 per cent. The number able to do some kind of work increased from 18.3 per cent to 59.6 per cent, and the number incapable of even minimal self-care decreased from 63 per cent to 18.3 per cent. Rusk considers the latter figure as relevant to dispelling the fallacy in the current emphasis on rehabilitation only for persons less severely disabled, those who are potentially fully employable. To use the words of Rusk: "Rehabilitation of the severely handicapped is no less valuable economically to the community than the rehabilitation of the less severely handicapped group. To teach a helpless person self-care releases other hands and often saves costly care of the individual in an institution or hospital; to teach a severely handicapped person how to do some work adds potential health to the community, even though he may represent only half a unit of manpower."

In the same paper Rusk examines the more tangible aspects of economic gains derived from rehabilitation by computing the income of 49 persons who had not been employed since disability and about whom the available facts on their ability to function and their total situation prior to rehabilitation indicated that they never would have been productively employed again without rehabilitation. The basic cost of rehabilitation of these 49 persons was around $149,000; their combined earning capacity was estimated at $96,000 per year. Consequently, the amount of their income in two years more than paid off the cost of their rehabilitation.

Special studies to evaluate the results of rehabilitation of paraplegic patients have been made by Bors,[8] Covalt,[9] Pollock,[10] Rusk,[11] and others. Paraplegia merits special consideration owing to the completeness of the disability, the high cost of continuous hospital care, and the fact that the paraplegic population is increasing, largely due to recent advances in medicine and surgery in combatting the severe complications accompanying injuries of the spinal cord. There were 400 traumatic paraplegics recorded in World War I, about 90 per cent of whom died during the first year of their disability. Only 2 paraplegics from World

War I are alive today.[11] Some 2,500 men became paraplegic as the result of World War II. Over 1,700 of the patients have been discharged from hospitals to their homes.

Since there is no mandatory reporting system for chronic disease and disability, we do not know the exact number of paraplegics in the United States, but the estimates, based on spot checks, range from 85,000 to 125,000.[11] If these estimates prove to be valid, the savings made by freeing these patients from continuous hospitalization would be enormous. One insurance company, for example, calculating on the basis of average expectancy, estimates that the cost of indemnity and continuous hospitalization of a single paraplegic patient would amount to $400,000.[12] The size of the economic problem and of human suffering has led one insurance company to conduct a follow-up study of its own. Hanson,[12] of the Liberty Mutual Insurance Company, of Boston, studied the savings obtained through rehabilitation, in both weekly indemnity payments and hospital costs, for 21 paraplegic patients for which the company was responsible under Workmen's Compensation laws. As the result of rehabilitation, all of these patients have been graduated from the necessity of continuous hospitalization. Fourteen of them have returned to some form of sedentary work or are engaged in their own businesses, varying from repairing watches to driving a truck with special controls. All of the 14 appear to have been permanently restored to a relatively normal family and community life. Hanson estimates that the rehabilitation of these patients saved the company $903,900.00 for an actual expenditure of $115,830.00 for the rehabilitation program.

To experience the full impact of paraplegic rehabilitation, let us examine the highlights of a case history of a medical colleague, a patient of Dr. Howard A. Rusk, of New York.

The patient, a 36-year-old woman physician, was shot 3 times with 32-caliber bullets by a psychotic patient who subsequently shot and killed himself. The physician-patient was transferred to a private hospital for emergency treatment. Examination revealed destruction of the articular facets and laminae of the twelfth thoracic vertebra, probable maceration of the spinal cord at this level with paraplegia and incontinence, and perforation of both lungs, liver, and stomach. The patient remained in the hospital for approximately 3 months, during which time her general health improved, decubitus ulcers were healed, and an indwelling catheter provided open drainage. There remained, however, a complete paralysis and sensory loss below the level of the twelfth thoracic vertebra. Around-the-clock medical care for this period amounted to $5,000.

For financial reasons she was transferred to the surgical service of a large city hospital, where she remained about 9 months. A tenotomy of the anterior tibial tendon was performed for contracture of the left foot. She did not have a neurologic evaluation. She was given braces and crutches, but was unable to use them. Hence, most of her time was spent in bed. Finally in March, 1952, about a year after her injury, she had contacted Dr. Rusk and made arrangements for transfer to the Bellevue Medical Center, where she was admitted to the Outpatient Rehabilitation program and was also enrolled as an assistant resident in physical medicine and rehabilitation. A complete neurologic work-up was performed, new braces were ordered, and urologic studies were begun. Rehabilitation began by retraining in activities of daily living, neuromuscular reëducation, and bladder training. After 5 months the patient had developed sufficient general endurance and substitute skills to lead an active life, to perform a "swing-through" gait independently, to climb stairs with a handrail, to perform all activities needed for self-care, and established automatic bladder.

At present the patient reports she is active as a resident on a rehabilitation service, her schedule being the same as other physicians, assuming patient responsibility, night duty and week-end duty; she is able to perform standard medical procedures, such as physical examination, muscle testing, changing catheters, lumbar punctures, infusions, and minor suturing.

This brief review of some of the studies on the results of rehabilitation in neurologic disorders does suggest, I believe, their general value. As previously mentioned, precise evaluations are difficult because of the lack of absolute controls. Moreover, modern rehabilitation has not been in operation long enough to prove its mettle beyond the shadow of a doubt. Nevertheless, for those of us who are close to the problem, it appears conservative to conclude that the weight of the evidence indicates that rehabilitation in many neurologic disorders is sound medical practice and often pays off in manpower conservation, long-term economic gains, and relief from human suffering.

NEUROLOGIC CONDITIONS AMENABLE TO REHABILITATION

There has been much controversy concerning what types of chronic neurologic conditions benefit from rehabilitation. In general, it can be said that almost all types of neurologic disorders can derive some benefit from rehabilitation, but that there is considerable variation in results obtained in different disorders and in different stages of the same disorder. I have seen much time and money wasted by the vigorous application of elaborate rehabilitation procedures to far advanced and progressive lesions of the central nervous system. As Schlesinger[5] observes, all neurologists too often see new complications arising from rehabilitation procedures because of unrealistic application of stress without adequate knowledge of their maximum obtainable efficiency under pathological conditions. Consequently, careful patient selection and painstaking evaluation of the disability and the therapeutic goal to be achieved are essential prerequisites for any neurologic rehabilitation program.

As a general rule, the neurologic conditions which respond best to rehabilitation are the stationary lesions of the central nervous system, whether caused by trauma or disease. To this group belongs the large number of hemiplegias and paraplegias of traumatic, vascular, infectious, or neoplastic origin; poliomyelitis; and certain of the cerebral palsies and epilepsies. According to Baker and Brown,[6] the specific conditions of this group in which the best results in relation to the severity of the disability have been obtained are the hemiplegias followed by the paraplegias, the ataxias, and flaccid paralyses, in the order named. Other factors which may influence substantially the therapeutic achievements of the group of patients are: age of the patient; general health; basic personality; socioeconomic status; time that rehabilitation is begun (all agree that rehabilitation process should begin when the emergency measures for the acute phase of the illness are combatted); and the amount of brain damage sustained or its specific effect on the patient's capacity for language communication, abstract thinking, and emotional stability.

The cerebral palsied belonging to this group are the nonprogressive disorders of childhood with average intelligence preserved. Here the spastics respond better to physical medicine and retraining than do the athetoids or ataxias. Here also the rehabilitation program has certain special features concerned with the development of educational facilities for preschool and school-age children, parent education, psychosocial adjustment, and even the solution of transportation difficulties.[13] The epilepsies belonging to this group are those cases of essential or acquired epilepsy whose seizures are reasonably controlled but who, because of the social stigma associated with the disease, are unable to adjust socially or to find employment. The major task in their rehabilitation is one of resocialization and job placement.

The second large group of patients that respond to rehabilitation less effectively than the first group are those with the slowly progressive lesions of the central nervous system and those who are subject to remissions and exacerbations. Included in this group are patients with parkinsonism, multiple sclerosis, and certain types of muscular dystrophy. In attempting to rehabilitate these patients, the physician, in a sense, is playing against loaded dice, for he never can hold his gains. The therapeutic goal, however, is to employ the patient's will and capacity so that he remains independent for as long a time as possible. Mild cases of parkinsonism, under adequate therapy, may achieve, for a time, a full vocational adjustment, but eventually most of these patients have to resort to avocations or hobbies.

The rehabilitation of patients with multiple sclerosis has been a point of controversy. The frequent association of remissions and exacerbations with the disease makes valid evaluation of progress difficult. Moreover, the problem assumes additional complexity because of the characteristic euphoria of some patients, which leads them to overstate therapeutic gains, and the medical adage that multiple sclerotics should not be exposed to exertion. Against these arguments are pitted the theory of Gordon,[14] that the maintenance of maximal physical activities prolongs the lives of many patients by avoiding complications such as bronchial pneumonia, thrombophlebitis, kidney stones, decubiti, etc. Informed medical circles advocate a rehabilitation program for carefully selected cases, except during the stage of acute exacerbation of symptoms. But the program should be individualized and realistic.

The final group of neurologic disorders least susceptible to rehabilitation are the rapidly progressive disseminated lesions of the nervous system. A good example is provided by amyotrophic lateral sclerosis, a rapidly progressive disease characterized by multiple lesions in the motor cells and tracts of the spinal cord and brain and terminating fatally in about three years. The brain stem nuclei may be affected, also causing bulbar palsy. In these cases the value of any organized rehabilitation appears doubtful. As Freeman[4] has pointed out, the hopeful attitude of the patient undergoing rehabilitation soon gives way to despondency as he observes the inexorable withering of his muscles, unchecked by treatment.

FUTURE OF NEUROLOGIC REHABILITATION

The expansion of modern rehabilitation programs as a part of medical practice has been real, but probably not as rapid as public enthusiasm indicates. Advances in the rehabilitation of neurologic patients have been more rapid and dramatic than in other fields. The use of modern rehabilitation methods is no longer confined almost solely to Government hospitals. Several programs are well under way in civilian medical centers; many others are being planned. The concept that chronic disease is a major medical problem which must be attacked with all available weapons in order to conserve the health and wealth of the Nation is receiving increasingly wider recognition in medical circles.

Research and training, which are fundamental to the growth and nourishment of any new medical activity, are increasing slowly in the rehabilitation field. The grants program of the National Institute of Neurological Diseases and Blindness now supports 10 rehabilitation research grants (an increase of 60 per cent during the last two years). It also supports 33 clinical fellows in rehabilitation and 14 rehabilitation trainees. Postgraduate courses in physical medicine and rehabilitation are definitely expanding in number and scope. And there is a slight trend for specialists in other fields, particularly neurology and neurosurgery, to transfer their basic knowledge and skills to the rehabilitation effort.

The values of the principles and practice of modern rehabilitation appear to be established in most medical groups. The fact that the movement has not developed with lightning speed is quite understandable when one considers the complexities of the organizational problems involved. Widening the scope of medical responsibility of the physician, adding factors to his relationship with paramedical groups and with community activities, altering the curricula of medical education, and developing new medical facilities at a time of construction and personnel shortages are not changes which can take place overnight. Moreover, a rehabilitation program, especially with reference to neurologic patients, requires an outlay of new funds which are not available to many hospitals

(Continued on page 69)

THE MANAGEMENT OF PATIENTS WHO HAVE MULTIPLE SCLEROSIS*

HAROLD RAOUL WAINERDI, M.D.

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WHEN a physician learns that his patient has multiple sclerosis, he is likely to be extremely pessimistic about the immediate outlook. I hope to convince you that this reaction is not warranted. There are, in fact, two types of iatrogenic tragedies seen in patients. The first not infrequently occurs when a patient is told, "You have multiple sclerosis and nothing can be done for you; go home." No one would talk like that to a patient with widespread cancer. The second, more common, type develops when a patient is allowed to believe that a supportive or symptomatic treatment is specific.

For this reason "management" better describes the regimen which in the light of our present knowledge has most to offer patients with multiple sclerosis. Our present knowledge does not permit us to use the word "cure" in connection with this disease, nor do lay persons understand how doctors qualify the word "treatment" as "supportive," "symptomatic," or "specific."

This is not merely a play on words; there are few diseases as capable of exciting fear and dread as multiple sclerosis. When words like "cure" or "treatment" are indiscriminately circulated, patients begin a round of terrifying, exhausting and futile pilgrimages to therapeutic mirages only to return exhausted in body, spirit and purse.

Many bizarre theories also afflict patients. I know of a woman who ascribes multiple sclerosis to the fact that parents tickle babies. Fortunately, her theory about the etiology of the disease is not widely entertained. This is admittedly extreme, but I could quote many other, equally meretricious, expressions.

How important is multiple sclerosis? Dr. Thomas Rivers[1] said that multiple sclerosis is the most important neurologic problem of our time. It has been variously estimated that there are from 200,000 to 300,000 cases in our country. The data are crude; multiple sclerosis is not a reportable disease. It usually has its onset in the third and fourth decades of life, a period which is, for the more fortunate, the prime of youth.

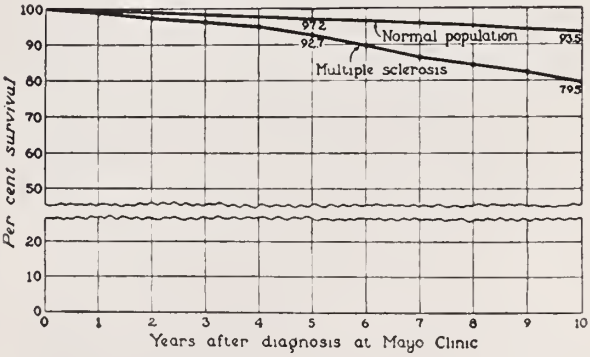

CHART 1. Survival curve of total group of patients with multiple sclerosis. The 5-year survival rate is 95 per cent of normal; the 10-year survival rate is 85 per cent of normal.[2]

However, the outlook is not completely bleak; most of those afflicted live for many years, during which they may usefully participate economically and socially. MacLean and Berkson,[2] in 1951, reporting 418 cases, noted that the 10-year survival rate was 85 per cent of that for the normal population. This becomes more remarkable when one realizes that this 10-year period was calculated from the "definitive" visit at which the diagnosis was determined. An average of 7 years had elapsed between the onset of symptoms and the definitive visit. Thus, 17 years after the onset of symptoms subsequently related to multiple sclerosis, the survival rate was 85 per cent of that of the "normal" population. This emphasizes the magnitude of our problem and the need for enthusiasm. I might add another remarkable fact established in this series: 42 per cent of the original 418 cases were gainfully employed 17 years after the onset of their sickness. The figures published are useful (charts 1 and 2).

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* Delivered at the 24th Annual Scientific Assembly of The Medical Society of the District of Columbia, October 7, 1953.

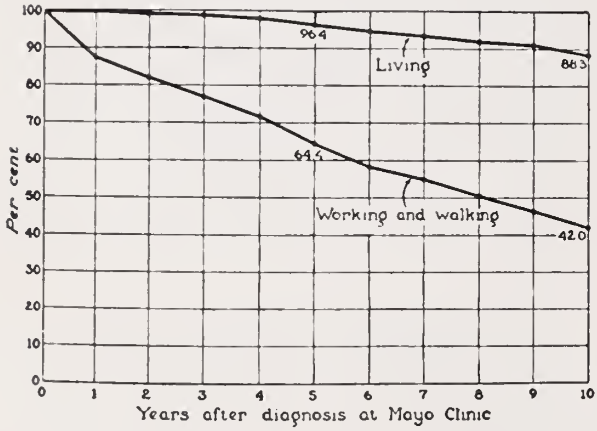

CHART 2. Group of patients who were walking and working at the time of the definitive visit. The upper curve shows the percentage living various years after the definitive visit; the lower curve shows the percentage walking and working.[2]

THE MANAGEMENT REGIMEN

It is important to realize that we treat the multiple sclerotic but not multiple sclerosis per se. A management regimen attempts to alleviate those dysfunctions which are secondary to the sclerotic lesion. In short, when the diagnosis has been established, management is not directed against the disease but aims at mitigating its consequences.

For this reason the management of the multiple sclerotic patient is, in my opinion, the responsibility of the interested and devoted general practitioner or internist. It will, however, always be necessary for the neurologist to remain close by. The services of other consultants, such as ophthalmologists, urologists, physiatrists, and orthopedists, are often required. Multiple sclerosis challenges every special discipline in medicine, but it is imperative, in the patient's interest, that his personal physician always be at the helm.

Many of the following suggestions may appear trite but merit repetition. First, a very detailed medical history should be taken. In clinic and in private practice, the Cornell Medical Index will be found an extremely useful adjunct.[3] (Presumably, a thorough neurologic study has been made, the diagnosis reasonably established, and the neurologic follow-up arranged.) Each patient should then have a most thorough general physical examination with particular emphasis on the hematologic, genitourinary, and musculoskeletal systems.

When this has been completed, a frank discussion of his or her situation should be had with every adult patient who is intellectually competent. I believe this should include a positive but not pessimistic discussion of the implications of the diagnosis of multiple sclerosis. With this statement many may disagree. I do not advocate telling the patient in a blunt or calloused manner, or that the unstable or extremely ill patients should so be informed. It has, however, been our experience that most adults have the capacity to accept such information when it is properly interpreted. This has been substantially established by Tarlau,[4] who analyzed over 300 responses to a questionnaire of the National Multiple Sclerosis Society. A great majority of the patients questioned *post facto* said that they believed patients should be so informed. Indeed, anyone who manages such situations is familiar with the disasters which may follow equivocation or evasion and which may add to the patient's burden a distrust of his doctors, his family, and his friends. Although multiple sclerosis imposes great hardships, the informed patient is usually coöperative. The doctor may properly call attention to research activity in this field and comment that pernicious anemia was once an incurable, rapidly fatal disease.

The Personality in Multiple Sclerosis

Psychotherapy is one form of treatment about which there is general agreement. Langworthy,[5] who has studied the personality in multiple sclerosis, defines psychotherapy as "... the use of the physician's personality to help the patient" and considers that it embraces "... the attitudes presented by the physician in an attempt to change the morbid attitudes of the patient." He points out that difficulties may arise from the physician's own attitudes about multiple sclerosis. "Unless the therapist is convinced," says Langworthy, "that the patient can be helped, he is impotent in any treatment situation." Obviously, an awareness of the fact that many multiple sclerotics do very well for long periods of time lends conviction to the managing physician which is both valid and psychotherapeutic.

Harrower[6] has directed extensive psychometric and personality tests in multiple sclerosis. Her group concluded: "Behavior of all the multiple sclerotic patients, even those most seriously disturbed, is unusually coöperative and friendly . . . they endeavor to win everybody for themselves, to interest the examiner in their cases. They want to excite sympathy and show their handicaps. . . . Their so-called euphoric mood seems to relate to their hope of finding help and their optimism as to the possibilities of healing. This confidence is shown even in patients who have been ill for some twenty years. . . ."

Elsewhere, Harrower and Kraus[7] reported that multiple sclerosis imposes conditions on the individual patient which modify the personality and take effect on intelligence. They found that few patients with advanced disease had superior or very superior intelligence quotients, and this group showed the most erratically developed personality structure and was most dependent.

I cannot here outline the psychologic management of patients with multiple sclerosis, but fortunately such information is available. The National Multiple Sclerosis Society now has available 2 excellent monographs by Dr. Harrower. One[8] of these is for physicians, and the other,[9] written from the lay point of view, is for patients.

Physical Medicine and Rehabilitation

Experiences managing war casualties have brought about a revolution in managing the handicapped patients with multiple sclerosis. Their problems are too many and too intricate to be considered at this time. Gordon has prepared 5 excellent monographs which can be had from the National Multiple Sclerosis Society. In 1, distributed only to physicians, the general problem is extensively reviewed.[10] The others are individualized for patients with various stages of disability. There is, for example, 1 for the ambulatory patient,[11] 1 for the patient ambulatory with aids,[12] another for the wheelchair patient,[13] and 1 for the patient confined to bed.[14] Simply written, well illustrated, they are strongly recommended to every doctor who treats patients with multiple sclerosis.

There are obvious, broad, social and economic consequences of any disease which cripples young adults. Much can be done for patients with multiple sclerosis if goals are modestly defined and revised as circumstances allow or require. You will recall that 17 years after the onset of multiple sclerosis 42 per cent of the 418 patients at the Mayo Clinic were ambulatory. Since we have continued to make great advances in the use of physical and rehabilitative modalities, the probability that more can now be accomplished is very real.

When I speak of rehabilitation I do not refer to diversional occupational therapy but rather to that enhancement of functional activities which leads to personal independence and to development of skills specifically useful in remunerative employment. We now realize the special therapeutic value of useful work; the patient who is optimally employed is often converted from a social and economic liability to an asset.

In 1950, Dr. Howard Rusk[15] discussed job placement potentials for the extremely handicapped as presented by a colleague who had studied 10 industries in Sweden. These observations resulted from matching the disabilities and handicaps of a hypothetical individual to the job requirements of the leather industry. This hypothetical patient "... was a 59-year-old man who was blind in 1 eye and color-blind in the other. He had pulmonary tuberculosis, which was quiescent. He had had rheumatic fever when he was young, and he had a heart murmur. He had arthritis in his elbows and shoulders, so that he only had so much motion, and he describes it technically. He was totally deaf, and he had had a severe psychoneurosis because of the multiple disabilities. His left leg was off above the knee, and his hands developed a severe rash when put in certain types of solution, the type of individual that the average personnel man would call the first aid crew ... for fear something would happen to him before he could get him out of the factory door.

"But that individual, matched against the jobs in the leather industry in Sweden, could do 50 per cent of all the jobs in that industry. ..."

Less spectacular, but equally important, is converting the patient wholly dependent on others to one who can manage for himself in larger part or completely. When this can be accomplished, a tremendous gain is achieved for the patient not only in his mental and physical status but in his social and economic adjustment.

Ataxia

Ataxia in minor or major degree is common and troublesome. Again, there is no specific remedy, but few patients utilize walking aids as early as they should. Certainly a stable tripod gait is preferable to 2-point unsteadiness. Canes should be heavy enough so that they do not bend under the pressure of the patient's weight, have good "suction" tips, and be cut to proper size.

Dr. John McKenna,[16] who has studied this problem for many years and who is himself afflicted, has discovered that putting the hand ipsilateral to his weaker leg into his rear trouser pocket greatly improves his equilibrium. I have suggested this to several patients with moderate gait difficulty and they have found it very useful. As in all crippling disease, the physician must be quick to recommend aids when indicated and, in multiple sclerosis, be alert to the need for withdrawing them from the patient whose remission may enable more physiologic ambulation.

Dysfunction of Vision

Nystagmus and oscillopsia, which are common aberrations of vision in early multiple sclerosis, are often not noticed by patients. A recent observation that the barbiturates modify nystagmus of certain types is not presently clinically applicable.[17] Diplopia, usually self-limiting, is extremely troublesome, and a simple occluding patch is a great comfort. Frames are available which, in addition to the usual lenses, feature a centrally hinged shield which may be turned to either side.*

Except that the fourth nerve is strikingly spared,[18] the ocular findings which are seen as the disease progresses may reflect almost any pattern of damage to the intrinsic and extrinsic ocular innervation. Beyond careful refraction, little can be accomplished, and since the difficulty appears to be in focusing, even refraction helps few. Recently, Jones[19] has found that corticotropin favorably influences retrobulbar neuritis in multiple sclerotics. This most important observation requires further study.

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* Available from Kono Manufacturing Co., Woodside, New York.

DIET

Most multiple sclerosis patients are poorly nourished; some are grossly overweight and a few are quite emaciated. Accordingly, diet is important in the over-all regimen.

At least 3 dietary regimens have been proposed for multiple sclerosis. In Germany, Evers[20] has claimed "cures" with a dietary program for which cancer "cures" have also been alleged. One's immediate reaction is to treat such claims with frank disbelief.

Another dietary regimen has been advocated by those who consider multiple sclerosis a syndrome of allergenic origin. Prigal[21] states that, although the possibility that multiple sclerosis may have an allergic etiology has not been disproven, the dietary regimens presently proposed for the allergic control of this disease are not rational.

Swank[22-4] has reported data suggesting that multiple sclerosis may be related to the fat content of the diet and that he has observed benefit in a large percentage of 47 patients treated. Swank acknowledges that "... adequate control for (his) results (was) not available ...," quoting Nathanson[25] and Müller[26] about the difficulties of control in clinical studies in which fat intake is limited to 20 to 30 grams. Further studies will employ the status of activity criteria proposed by Alexander.[27]

In the sense of specificity, there is no dietary regimen for multiple sclerosis other than that familiar to all who treat all types of chronic, wasting illnesses. Patients should be kept in good protein balance and within accepted weight-height limits. It is well to remember that individualized exercise and conditioning programs go far to overcome the anorexia of the inactive patient.

It is probably desirable for patients with multiple sclerosis to have daily vitamin supplements. Unless extremely ill, a multivitamin preparation, once daily, should suffice. There has been some advocacy of the addition of so-called "trace elements" which at present appear to contribute only to the cost of these preparations.

Except where the attendant anemia is of the megaloblastic type, neither liver nor B_{12} is indicated. B_{12} has been advocated in multiple sclerosis, but Booth, Lawyer and von Storch[28] showed that no benefit was derived from doses as high as 1,000 gamma daily for as long as 3 to 7 months.

DRUG THERAPY

In 1936 Brickner[29] published a comprehensive review of over 100 forms of treatment which had been described in the literature, and 3 years later Putnam,[30] who analyzed them statistically, found that reported improvement from such treatments corresponded almost exactly (48 per cent) with the frequency with which the initial symptom-complex of multiple sclerosis spontaneously goes into remission.

Three types of drug therapy based on as many theories of the etiology of this disease have had some contemporary popularity. One, premised on the theory that the sclerotic plaque is the end-result of multiple thrombi, employs anticoagulants such as Dicumerol. Another approach to multiple sclerosis as, at least in part, a circulation phenomenon, employs various vasodilators. The third, which considers this a disease of allergenic origin, comprises various desensitizing procedures.

Although these theories and therapies have some distinguished advocates and require more study, most authorities are not enthusiastic about them, and they are not at this point included in the supportive and symptomatic management program herein outlined.

Spasmolytic agents. A reliable and safe spasmolytic agent would be a valuable asset; none is currently available. Myanesin and the curare-like drugs have proven disappointing; they are neither safe nor dependable. They may be cautiously tried, and in a few instances dramatic alleviation of painful spasms has been attributed to them. Careful blood studies are indicated when myanesin is used, since severe hematopoietic depression has been reported. The use of hot, moist packs is safest and most often effective.

Except for the possible value of corticotropin in retrobulbar neuritis, to which reference has been made, neither corticotropin, cortisone, nor any other hormonal agent has an established role in the treatment of multiple sclerosis.[31]

Pain, emotional lability, depression, insomnia, anemias and decubiti are among the other problems which require appropriate narcotic, sedative, mood-lifting, hematinic and antibiotic treatment. The usual precautions for prescribing narcotics and sedatives in small total amounts are important. Aspirin, triple bromides and paraldehyde are preferred to the morphine alkaloids when the former are effective. Similarly, chloral hydrate is preferred to the barbiturates. As the disease progresses the stronger agents are often required and even pain-relieving neurosurgical procedures may eventually be required.

Iron. Many patients with multiple sclerosis have a hypochromic, microcytic anemia undoubtedly nutritional in origin, treatment of which is complicated by profound anorexia. When the hemoglobin is less than 10 Gm. per 100 ml., 1 or more transfusions of whole blood or washed cells may be indicated. This not only enhances the blood status but benefits general tone and may influence anorexia.

In more moderate anemias, those in the range of 10 to 12 Gm. of hemoglobin per 100 ml., simple preparations containing iron are indicated, but their use may be complicated since they constipate many patients. In multiple sclerosis, in which bowel problems are common, this can be very serious.

Bladder Management

Dysuria of almost every type is commonly encountered, to which both psychologic and organic causes contribute. Frequency and stress incontinence are most common; in advanced cases the urinary pattern may be substantially that of a cord bladder.

Buchwald, McCormack and Raby[32] studied 55 patients with various types of advanced spinal cord disease including multiple sclerosis. Their training procedures are practical applications of pioneering work by Deaver[33] and by Munro.[34] Their discussion of bladder training should be studied by every doctor who faces this problem, and for teaching purposes an excellent filmstrip on the subject is available.[35]

Each patient who complains of dysuria should be closely questioned as to his toilet schedule, and almost invariably clues will be found from which bladder and even bowel rehabilitation may be developed. Many of these patients have psychologic trigger mechanisms in which apprehension of incontinence features prominently. For others the ingestion of fluids at specified times promotes desirable reflex patterns. In others, stress urgency may be combated by intellectual concentration on distracting subjects. An example is the case of a patient with multiple sclerosis for many years who often developed urgency as he approached his doorstep. Worrying whether he would "make it" usually exaggerated his difficulty. He has learned that forcing himself to concentrate on a mathematical problem effectively diverts his urgency. Himself a physician, he has successfully suggested this method to several of his patients similarly afflicted.

Muellner and his associates[36] in Boston have carefully studied urinary dysfunction in multiple sclerosis by fluoroscopic as well as the more usual neurologic and urologic approaches. They particularly recommend evaluation of the voluntary control of the perineum. In their experience with 35 multiple sclerosis patients, dysuria was easily controlled when the levatores ani could be voluntarily contracted or relaxed.

They found detrusor spasm and a hypertonic bladder common causes of urinary retention and consider atropine sulfate, 0.4 mg. (1/150 gr.) twice daily or more frequently, the most useful agent for inducing relaxation of the detrusor. Where there is atropine intolerance, panparnit or amphetamine sulfate, 20 to 40 mg. daily, may be used. The reverse situation is often encountered in later stages of multiple sclerosis when atonia is more commonly encountered. Urocholine chloride, 5–20 mg. 2 or more times a day, may improve detrusor tone.

In advanced cases the methods developed for care of the paraplegic bladder must be considered, and there are of course those cases in which damage is so extensive that the problem is one of painstaking nursing.

Bowel Dysfunction

Bowel dysfunction of varying severity is a common complaint of multiple sclerotics. For most patients in the early phases constipation is common; later, incontinence may be complete.

The constipation encountered in the early stages is not due only to intrinsic disturbances of innervation to sphincters, levatores ani and to the abdominals, but generalized asthenia, anorexia, and deterioration of conditioned bowel reflex patterns also contribute.

Again, although no medication is available which alters the intrinsic disease process, most patients can be helped greatly by judicious study and revision of eating and stool schedules. Patients should be on the commode at regular times each day and should be assisted by cathartics, suppositories or enemas as required. Pressure by the patient against his hypogastrium during maximum inhalation may make voluntary defecation possible. Oral medications which contain constipating materials such as iron salts should be cautiously administered, and such agents may have to be given parenterally.

For those who have completely lost voluntary bowel control the problem is essentially one of sanitation rather than retraining, but no patient should be considered beyond retraining until strenuous efforts have failed to establish some improvement in bowel control. When such a program does not avail, the garments and other devices developed for paraplegics will be found extremely useful and are well described in the reference cited.[37]

Conclusion

You will recall the stress I placed on the term "management" as best describing the symptomatic, supportive and expectant treatment which, as the individual's condition may require, constitutes the desired regimen for the patient who has multiple sclerosis. Although, in the light of present knowledge, no specific agents are known, every patient should benefit to major or minor degree from the skillful use of those modalities which are well understood, economical, readily available, and enjoy wide margins of safety.

You may be sure that as it is possible to expand this regimen as new and better agents, whether symptomatic or specific in nature, become available, such data will be widely publicized either in the periodical literature or directly by the National Multiple Sclerosis Society, which I hope you will consider your service agency in this difficult field. Its services are at your disposal at any time and without charge.

Having made the burden of this address the nonspecificity of the measures recommended, I would like you to indulge me in some modest speculation. There is no doubt that an intensive management program must favorably affect the degree of dysfunction attributable to multiple sclerosis in many patients. It may even modify, in some individuals, the progress of the disease itself.

That dysfunction may be minimized by sedulous supportive and symptomatic management appears obvious. I am convinced that the strong psychotherapeutic support which devoted physicians give explains many apparent "miracles." Carried further and considered against the background of remissions and exacerbations which occur in cases of multiple sclerosis, it is reasonable to believe that functions neglected in whole or in part during exacerbations may not partake of the full value of remissions when they do occur.

I am sure that the foregoing is reasonable, but you may not be as willing to accept another speculation. Although we know nothing of the etiology and too little of the nature of multiple sclerosis, is it not reasonable to presume that the patient who is maintained at the highest possible physical and psychologic levels may resist the intrinsic disease process better than the patient who is neglected, discouraged and whose condition has consequently deteriorated? With few exceptions this general rule obtains in medicine, and it seems reasonable to consider that it applies here.

I am appalled by the magnitude of the problem of multiple sclerosis and the extent of work yet to be done, but when I think of other diseases which medicine has conquered, I am not discouraged. We all know that it is now difficult to show medical students examples of many diseases which were once epidemic and ravished whole populations. If we are diligent, aware of possibilities, and fortunate, the day may come when multiple sclerosis is as rare.

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THERAPY IN MUSCULAR DYSTROPHY*

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ALTHOUGH the therapy of muscular dystrophy still is unsatisfactory, and a statement regarding the lack of specific effective treatment could be made in a small fraction of the time allotted to me on the program this afternoon, it appears of interest and profit to consider the bases on which treatment was attempted in the past and on which therapy is now being sought. Moreover, two types of circumstances often contributing in no small way to the patient's disability may be managed even in the absence of a specific treatment for the underlying morbid process of muscular dystrophy. These are the emotional reaction of the patient to a crippling disease of grave prognosis and the contractures, which in many instances transform an ambulatory patient to one who is confined to a wheel chair.

An evaluation of the efforts now being made to develop satisfactory therapy, an appreciation of the need for these efforts in terms of economic loss, disability, and tragedy to the patients and their families, and an opinion whether the future offers much or little to patients with this disease must be based on a consideration of the following questions: What is the incidence of muscular dystrophy? What is the nature of the disease, and what factors can influence the development of disability? What is the relation of the several different forms of the disease to one another? Does the fact that muscular dystrophy often is inherited make it less likely that successful treatment will be available? On the basis of our present knowledge, what suppositions can be made regarding probable trails of investigation for a treatment? And finally, what may we reasonably expect could be accomplished by the treatment of a disease characterized by loss of the contractile structures of striated muscle and their replacement by fat and connective tissue? It is probable that in this discussion we shall raise more questions than we shall answer.

When we use the designation "muscular dystrophy" we usually mean muscular dystrophy of the commonly recognized forms that are inherited, for example, the pseudohypertrophic form of infancy and childhood and the facio-scapulo-humeral form having its onset at about puberty. However, a significant number of the patients whom we now see for the first time are adults whose first symptoms are noted during the later periods of life. In many of these patients the clinical and laboratory findings are similar to those seen in the inherited forms of the disease, but, in a few, evidence of an inflammatory process resembling that of myositis and dermatomyositis may be demonstrated. In addition to these forms, one may rightfully include in the designation of "muscular dystrophy" the muscular wasting that is associated with hyperthyroidism. Hyperthyroidism is fairly well understood, and in most instances may be satisfactorily treated, but we are still largely ignorant of the nature of the processes that lead to the atrophy of striated muscle in this condition.

Although muscular dystrophy does not occur with as great a frequency as certain other conditions, we should in no way consider it a disease of great rarity. Definite data on actual prevalence are not available, but the estimate of from 100,000 to 200,000 patients in this country made by certain organizations and insurance companies seems reasonable. In certain areas, as, for example, in the state of Utah, as many as 1 person out of every 500 of the population are estimated to have muscular dystrophy of the inherited forms, and in all areas, wherever there are clinics that show an interest in this disease, appreciable numbers of patients become known to the medical profession. Some of these patients are persons in whom the disease had not previously been diagnosed, and others had been seen by physicians but, because no treatment was available or for other reasons, had not revisited their physicians for periods of as long as several years. Since the number of patients in these two last groups is considerable, it is apparent that the number of patients now consulting physicians is only a fraction of the total number of persons affected with muscular dystrophy.

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In addition, consideration of the serious nature of the disease, with its progressive increase in disability to complete infirmity and death, must establish the disorder as one of the important diseases of childhood.

More specifically, what are these serious features of muscular dystrophy? First, muscular dystrophy is characterized by weakness and wasting of the striated muscles. Second, the course is progressive and without remissions. The muscles earliest and most severely damaged usually are those of the proximal groups, but eventually practically all of the voluntary muscles of the body atrophy and are replaced by fat and connective tissue. Although on rare occasions one sees a patient whose symptoms, typical of muscular dystrophy, show definite evidence of improving, this course is so unusual that the diagnosis of muscular dystrophy must be reconsidered. In a series of about 400 cases, spontaneous improvement occurred in only 5. Third, contractures, especially about the ankles and knees, may develop and seriously restrict movement. Fourth, the combination of muscular wasting and contractures renders the patient completely infirm. In the final stages, expulsion of mucus from the trachea may not be possible and the patient can suffocate as the result of a relatively mild respiratory infection. In a few instances, cardiac involvement, which is not as rare in this disease as was previously believed, can be the cause of death.

It should be noted particularly that in two of the most frequently observed forms that are of hereditary nature, namely, the pseudohypertrophic form and the facio-scapulo-humeral type, there is a characteristic difference in so far as the involvement of the facial muscles is concerned. In the pseudohypertrophic form the facial muscles usually are spared; in the final stages of this disease, the contrast between the normal facial musculature and the advanced wasting of practically all other muscular groups is striking. On the other hand, in the facio-scapulo-humeral form the face is involved early and usually to an extent that makes diagnosis easy. Atrophy of the facial muscles may be seen many years before other muscles are affected to any significant extent. This difference is important in our consideration of treatment, because in our present state of knowledge we recognize these different inherited types not as different diseases but merely as different forms of one large pathologic unit.

I have long sought a plausible explanation for the difference in involvement of the various muscular groups. Known differences in the chemical composition of cardiac and striated muscle might conceivably explain the differences in the incidence and severity of the lesions in these types of muscle, but why the differences in wasting of the different groups of voluntary muscle? The work of Dr. Samuel Leonard[1–4] of Cornell University, Ithaca, New York, might be pertinent to this question. Leonard determined the glycogen content of 3 different muscle groups of rats subjected to castration or hypophysectomy, and investigated certain hormones for their glycostatic effect in these muscles. He observed that although each group always responded in the same way, there were significant differences among the 3 groups of muscles to these procedures. Does the sparing of the facial muscles in the pseudohypertrophic form and their early involvement in the facio-scapulo-humeral form imply a difference in the underlying process? We shall probably have to re-examine the commonly held opinion that the different clinical forms of the disease are merely different types of the same large unit. Hence, a therapeutic agent effective in one type of the disease need not be effective in another.

The most commonly recognized chemical abnormalities are excessive urinary output of creatine, diminished urinary excretion of creatinine, and diminished concentrations of creatine, glycogen and potassium in the muscle.[5] The amounts of fat and sodium in the muscle are increased. Although it is probable that future additions to our knowledge of the metabolism of creatine will surpass our present speculations, the data already available are considerable and have stimulated certain approaches to the treatment of muscular dystrophy.

All of the known precursors of creatine have been used for therapeutic effects, but without positive result. Glycine at first appeared to be of benefit in reducing disability in the facio-scapulo-humeral form of the disease, but subsequent observations on many patients did not confirm these earlier hopes. More recently glycocyamine or guanidoacetic acid given with betaine, a methylating agent, has been used. Objective evidence of the value of these compounds is lacking.

Adenosine triphosphate (ATP), a substance utilized by the body for the phosphorylation of creatine and a large number of other compounds important in the organism, has been studied quite extensively. In our own experience and in that of other investigators, ATP never has been observed to be of any therapeutic value whatever. Persson[6] recently reported that ATP was of therapeutic value in 5 children with muscular dystrophy. He noted improvement in muscular function and reduction of creatinuria. Although the effects were ascribed to ATP, the preparation employed by Persson contained only minimal amounts of ATP and consisted mainly of adenosine-3-monophosphate. The identical preparation has been studied in our clinic during the past year or more, but unfortunately without the results noted by Persson. A few patients with muscular dystrophy appeared to be subjectively improved, but similar changes were noted in patients with muscular wasting subsequent to disease of the spinal cord. Related compounds, including adenosine-5-monophosphate likewise were without therapeutic effect.

A list of vitamins, hormones, chemical substances, and procedures tested for therapeutic value in muscular dystrophy is shown in table 1. The most that one can say of almost all of these compounds is that, at the dosage levels at which they were administered, no significant toxic effects were produced. However, it should be noted that the apprehension of patients, and particularly of their parents, is of an order that clinical improvement is sought with anxious eye, with the result that some patients react favorably with subjective improvement each time a new substance is tried. This subjective improvement usually persists for periods of from 2 to 5 weeks but gradually subsides on continued administration. One extreme example is the case of a father who, despite contrary objective evidence, insisted that his son was improving steadily as the result of a preparation of secret formula administered under circumstances not favorably considered by most medical investigators, until his child, who had been ambulatory when treatment was started, could no longer walk and was confined to a wheel chair.

It is apparent that many substances act through suggestion or give hope and thereby improve the emotional status without changing the underlying muscular defects. On the other hand, an occasional patient whose previous dietary had been subnormal will be benefited by substances that satisfy these nutritional defects, but this improvement should not be at-

TABLE 1

Substances and Procedures that Have Been Used in the Treatment of Muscular Dystrophy

NOTE. None of the substances listed has been shown to have any significant lasting effect on the course of the disease.

VITAMINS AND RELATED SUBSTANCES

Vitamin A
Thiamine hydrochloride
Pyridoxine hydrochloride*
Calcium pantothenate
Riboflavin
Nicotinamide
Folic acid
Vitamin B_{12}
Para-aminobenzoic acid
Ascorbic acid*
Vitamin E*
Alpha tocopherol* (natural, synthetic)
Tocopheryl phosphate*
Delta-tocopherol*
Tocopheramine*
Alpha-tocopherylhydroquinone*
Tocopherol + inositol*
Wheat germ*
Wheat germ oil* (cold pressed and extracted)
Corn oil
Liver extracts*
Lecithin
Lyxoflavin
Stigmasterol
Ergostanyl acetate
Soybean sterols
Mixtures of all known vitamins
Dimethylaminoacetate of gluconic acid

ENZYMES AND RELATED COMPOUNDS

Coenzyme A (from liver)
Cytochrome C
Adenosinetriphosphate* (ATP)
Adenosine-3-monophosphate*
Adenosine-5-monophosphate
Procaine adenylate*

PRODUCTS OF GASTROINTESTINAL TRACT

Mucin of hog stomach*
Extracts of hog stomach linings
Extracts of pancreas, pancreatic ferments*
Extracts of duodenum

PROTEINS, AMINO ACIDS AND RELATED SUBSTANCES

Amino acetic acid* (glycine)
Glutamic acid*
Arginine
Methionine*
Lysine
Cyteine*
Hydrolysate of liver protein (pancreatic digestion)
Gelatine*
Creatine
Glycocyamine
Betaine
Choline
Desiccated liver
Nucleic acid
Sodium desoxyribonucleate

HORMONES AND RELATED SUBSTANCES

Testosterone* (methyltestosterone, testosteronepropionate)
Insulin*
Epinephrine with pilocarpine*
Ephedrine*
Adrenocorticotropin (ACTH)
Adrenocortical extracts of various types*
Growth hormone of the anterior pituitary
Pituitary thyrotropic hormone
Thyroid extract*

SUGARS AND SUGAR ALCOHOLS

Inositol
Arabinose
Galactose
Lactose
Mannose*
Mannitol
Raffinose

DIETS

Meat-free
High fruit and vegetable*
High protein

REDUCING AGENTS

Methylene blue
Butylated hydroxyanisole

ANTIMICROBIAL AGENTS

Sulfadiazine
Terramycin
Aureomycin

MISCELLANEOUS

Strychnine*
Phenylbutazone
Fever therapy* (malaria)
Resection of nerves of carotid bodies*
Iontophoresis* (calcium)

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* Reported to be of therapeutic value, or found, in an occasional patient, to produce mild effects.

tributed to any specific effect on the dystrophic process. Unless all of these circumstances are properly evaluated, and sometimes this will not be easy, unduly optimistic reports on therapy will continue to be published. The following are direct quotations from a few reports of this kind: "In the myopathic group, the results of treatment with vitamin E were remarkable."[7] "Five of 6 patients treated with synthetic vitamin B_6 were definitely benefited as to muscular strength."[8] "In early cases, pancreatic extracts produce complete cure."[9] "Malaria therapy induced definite improvement in muscle function."[10] "Injections of adrenalin and pilocarpin have a curative effect in muscular dystrophy; their least effect is to check progress of the disease."[11] Despite this original enthusiasm, none of these agents now has an accepted place in the treatment of muscular dystrophy. The time required to disprove such incorrect reports usually is about 2 years. Finally, the lay press should appreciate more fully the effect of premature newspaper publicity of such reports on apprehensive patients and parents whose interests would be served better by increased coöperation and understanding between the lay press and the medical profession.

Muscular dystrophy often is inherited.[12, 13] In about 35 per cent of the patients one may obtain a history of at least one other member of the family similarly affected. In the pseudohypertrophic form, hereditary transmission usually is by a sex-linked recessive factor. Inheritance in the facio-scapulo-humeral form is direct and by a dominant factor. In our discussion of therapy, the question naturally arises whether the fact that muscular dystrophy often is hereditary diminishes our hope for eventual effective treatment. Some students of the problem would answer in the affirmative, as did one[14] who stated, "The untiring efforts of the medical profession can do little to alleviate the condition once it has been allowed to arise; indeed they cannot be expected to do so any more than they can be expected to turn a blue eye into a brown one." The large mass of experimental data now available justifies a more optimistic opinion. Most metabolic processes require a large number of successive steps each of which is determined by a specific enzyme that is related to a specific gene. The older view of a fixed hereditarily determined state which we might be powerless to alter has been replaced with the modern view[15, 16] that an inherited defect is the result of failure in a specific enzymatic reaction determined by the altered gene and may be compensated for, if only we have definitive knowledge of the site and type of the defect, as, for example, in the case of diabetes.

What speculations may be made at the present time regarding this inherited defect? Experimental observations suggest at least a few possible paths that should be investigated. Schapira and Dreyfus[17] of Paris have noted an early loss of the enzyme aldolase, which is concerned in the metabolism of carbohydrates, from the muscles of patients with muscular dystrophy. Since loss of muscle glycogen is associated with creatinuria[18] and occurs early in various types of muscle atrophy, more definitive data on the metabolism of carbohydrates in muscle are needed to ascertain whether these changes are of secondary or primary nature. Similarly, defects in potassium, as shown by Blahd, Rose and others,[19] which likewise occur early in the wasting muscle and especially in muscular dystrophy should be studied to determine the relation of these changes to atrophy. Dr. Weinstock,[20] of our laboratory, has noted pronounced defects in the Krebs oxidation cycle in the liver of rabbits with an experimental form of muscular dystrophy. The implications are important, since the histologic alterations in these animals are limited to the muscles. Could it be that in muscular dystrophy in man the striated muscle is the end organ and shows advanced structural damage, but that the primary metabolic defect is elsewhere, for example in the liver? Another finding of interest, in the trail of research toward an effective treatment, is the finding by Dr.

Anne Milman,[21] also of our laboratory, suggesting that in these animals with an experimental form of muscular dystrophy the rate of protein breakdown is diminished. Since the muscles are wasting at a rapid rate, the interpretation of the data would suggest further that the rate of resynthesis of protein is depressed. According to the concept of "dynamic equilibrium,"[22] tissues of the body are constantly being degraded and built up. One may ask, is the loss of protein or, in other words, the muscular wasting in muscular dystrophy the result of diminished protein synthesis?

Finally, there is the work on vitamin E both in experimental muscular dystrophy in animals and in muscular dystrophy in man. We have previously stated that none of the vitamins tested in patients has been found to be of therapeutic value. This statement is true of vitamin E if we refer to alpha-tocopherol, the form of vitamin E found in foods. There is no evidence of a deficiency of tocopherol in patients; the absorption of the vitamin from the intestines is normal,[23] and the concentrations of this substance in the tissues are not diminished.[24] Experiments in animals show that certain structural changes may be made in the tocopherol molecule without abolishing effectiveness in curing muscular dystrophy of vitamin E-deprivation.[25] Of interest is the fact that certain of these derivatives may reduce the creatinuria of patients, although alpha-tocopherol itself has no effect. Experiments indicate that tocopherol functions in an oxidation-reduction cycle, and it is possible that in muscular dystrophy there is an important defect in this cycle.[5] Certain reducing agents, and especially ferrous iron, reduce creatinuria, possibly through an effect on these oxidation-reduction reactions. Certain derivatives of tocopherol are being studied for leads to effective therapy.

We have so far discussed muscular dystrophy of the inherited forms. Another type, seen quite often, is muscular dystrophy having its onset during the later periods of life. This form was designated by McEachern[26] as "menopausal muscular dystrophy," but in our experience it affects one sex as often as the other. Although of late onset and not familial, many of these cases satisfy all of the diagnostic criteria of muscular dystrophy. A large proportion of the patients, however, may be shown, by microscopic study of the muscle, to have diffuse myositis. Many of the patients with myositis show improvement when cortisone is given, whereas the other patients with symptoms of late onset do not. Hence the importance of correct diagnosis. Cortisone is without effect in muscular dystrophy of the pseudohypertrophic and facio-scapulo-humeral types.[27] As a matter of fact, on the basis of laboratory evidence, it would appear to be contraindicated, although at the dosage levels commonly employed, unfavorable effects are not noted. The increase in creatinuria reminds one of the gross creatinuria produced in normal rabbits by large doses of the hormone.[28] Other hormones, such as testosterone and the growth hormone of the anterior pituitary, are without benefit to patients, except that testosterone in certain patients may produce a feeling of well-being without improving the underlying muscular process.

Occasionally, the muscular changes of Graves' disease simulate those of progressive muscular dystrophy. The treatment of Graves' disease is too well understood to warrant much discussion at this time. However, whereas in many cases the diagnosis of hyperthyroidism may be obvious, in some the signs of thyroid dysfunction may be obscure. It is known that the muscular changes of Graves' disease are associated with gross creatinuria which may be abolished by administration of iodine, whereas the creatinuria of muscular dystrophy is not influenced by iodine. The use of this test will, in certain cases, indicate the proper treatment; obviously when muscular wasting and dysfunction are induced or increased by Graves' disease, the management must include the treatment of the hyperthyroidism.

The actual role of physical therapy in muscular dystrophy has not yet been adequately evaluated, but the results of one carefully controlled pilot study[29] were as follows:

1. In about half of the children, physical therapy appeared to be of value in that muscle strength was improved, not to a great extent, but sufficiently to warrant the conclusion that at least something had been accomplished.

2. In 18 of 27 patients contractures were improved. The improvement rarely was a return to normal, but in some cases it was considerable.

3. Many patients, because of overindulgence on the part of the parents, do not perform many functions they still are able to perform and, in short, anticipate the disability that the natural course of the disease produces. The physical therapist, in his tests of muscle function, may indicate to the patient activities of which the patient still is capable but is not aware.

4. Improvement when it occurred was most rapid during the first 8 or 10 weeks of treatment, after which there was a leveling off.

Although emotional reactions of patients to their disease have long been recognized,[31] the magnitude of these reactions was not appreciated until these patients could be observed carefully by physicians and nurses trained in psychiatry. Briefly, the results of these studies were as follows: The emotions of the patient were determined in large part by the personality makeup, by the reaction to the illness, and by the relations to the family. There were a surprising number of erotic behaviors which apparently had either been tolerated by the family or not recognized. There was a surprising amount of rebelliousness to routine which likewise had been tolerated by the family. A small group suppressed their emotions and beneath their smiling faces harbored much resentment. There were certain poor personal behaviors like those of a spoiled child. Other reactions that were observed had been expected, such as a certain amount of self-centeredness, depression, unhappiness, and somatic complaints. Many patients on admission to the hospital showed behavior disturbances that would not fit into any well-controlled group. Therapy at present is on an individual basis. In the management of sexual reactions, the understanding of parents to avoid sexual stimulation is needed. Treatment in the form of education should be started during the earliest stages of the disease. The most effective method of treating these emotional stages must still be developed, and it is likely that in such treatment the social worker will have an important role.

Finally, a word must be said about the management of the patient in an advanced stage of the disease and who has a respiratory infection. Such patients have difficulty in expelling mucus from the trachea, and with alarming rapidity may develop cyanosis and suffocate. The physician should be alert and remember that bronchoscopic aspiration may be a lifesaving measure.

I fear that, as anticipated, I have asked more questions than I have answered. For the patient with muscular dystrophy, the present is gloomy, but the future, in my opinion, is bright with the promise of effective treatment. It is my hope that it will not be long before what I have said today will be mere history, and in its place we shall have the answers to these and other questions and a specific therapy for this dread disease.

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(*Continued on page 70*)

THE PSYCHIATRIC ASPECTS OF FATIGUE

Emotional Fatigue, Fatigue States and Neurasthenia*

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FATIGUE is a common symptom. It is seen frequently by physicians in association with a wide range of emotional and physical conditions. The ordinary connotation of fatigue refers to the subjective feelings following physical exertion and work. Society approves of the hard worker and in general the complaint of fatigue is more apt to engender approval than the reverse. Thus, we have a symptom which at the outset tends to be socially acceptable. A man may suffer from considerable fatigue, in the face of what are actually light duties. The implications of his symptoms, being those of hard labor or overwork, tend to secure him sympathy, kindly regard, perhaps even admiration, and the result can be ego-building. The response of friends, family and physician is more likely to be kindly, sympathetic and understanding when symptoms of fatigue are presented than with certain other manifestations of emotional illness.

Since fatigue is ordinarily associated with physical exertion, there may be a tendency to overlook the very common fatigue from mental effort and that following emotional conflict. While fatigue is not too often seen in "pure culture," one can nevertheless make an arbitrary classification of (1) mental fatigue, (2) physical fatigue, and (3) emotional fatigue. We shall be primarily concerned in the present discussion with the last. Fatigue on a primarily emotional basis is very frequently encountered in all types of medical practice and well warrants our study.

Fatigue and Fatigue States

Emotional fatigue. The fatigue state is that condition in which the most prominent feature is fatigue. As Dr. Frederick C. Fishback noted when this paper was read, there is confusion in the employment of the same term, fatigue, which more often denotes the muscular fatigue following physical exertion, to also describe the fatigue from mental effort and emotional conflict. However, we currently lack a better one. Patients also use the same term. My own preference is to use "emotional fatigue" to describe the latter. This type of fatigue when present is out of proportion to actual physical activity performed and can be traced largely to emotional origins. Actually, the exhausting effect of emotional stress is a commonplace experience. The efficient housewife may be able to accomplish an amazing amount of housework with relatively little resulting fatigue. However, if a conflicting problem arises with her husband, for example, or if several small demanding children are added, her threshold to fatigue may be substantially lowered.

At a recent meeting attended by representatives of most of the major medical specialties, I solicited their medical experience with regard to fatigue as a symptom. The internists present roughly estimated that from 30 per cent to nearly half of their patients complained of fatigue in some form. The obstetricians and gynecologists estimated it to be a symptom of major frequency, and other specialists described it as "common," "often seen" and "frequent." A pediatrician commented that while it was a rare complaint among his patients, it seemed a most usual one of their parents.

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Patients with emotional fatigue report how tired, worn-out or exhausted they are. The following are fairly typical comments made by patients, which in an instance or so also suggest something about the underlying dynamics:

"Doctor, I'm just so tired all the time. I can't seem to get things done any more."

"Since the baby came I've been exhausted. By the time we get her to bed I can hardly raise a hand. I can't understand it. Fred (the husband) helps me every evening, and the maid is here nearly every day, but it all just seems too much."

"I'm just tired of everything. I feel worn-out all the time. I don't want to go any place. When evening comes, all I want to do is to climb into bed."

"Sometimes I'm just so tired I can hardly drag myself down to the office. Sleep doesn't seem to do me much good. When I get up in the morning I'm tired. I used to have a lot of pep and energy and I don't know what's happened to it."

The close relation of fatigue to interest and ambition is widely recognized. When the level of personal interest in a task or activity is high, there is a greater performance potential, and fatigue occurs less readily. Thus, when the motivation or incentive is increased, the onset of fatigue is impeded, or, from the other viewpoint, work potential is increased. There is also the compulsively "driven" person who may have little subjective awareness of fatigue and who may seemingly possess almost boundless "stores" of available energy. This may also be noted to apply in cases of manic psychoses or hypomanic excitement. In these latter the speculation might be raised as to whether a process of psychic fatigue might help account for some cases where a depressed phase closely succeeds a manic state, in which inordinate amounts of physical and psychic energy had been expended. From the organic side, the hyperthyroid may also give this impression.

In testing the effects of motivation level in the simple exercise test of hanging on to a horizontal bar, Schwab and DeLorme[1] found that the usual time was substantially increased by the offer of a reward. Similar resistance to fatigue can take place in more complex fashion psychologically, as illustrated in the gaining of renewed work interest, motivation, and incentive in the following case, concurrently with the disappearance of handicapping fatigue during treatment.

Case 1. A 40-year-old Federal executive was originally referred to treatment because of symptoms which included chronic fatigue accompanied by decreasing work performance. The fatigue was somewhat characteristically greater in the morning, with improvement during the day. As evening approached, however, he still felt too tired for social activities. As he explained it, "I have no energy left." Sleep was described as restless, and it seemed to him to have lost much of its restorative value.

Ordinarily ambitious and energetic, this patient had achieved a high degree of success in Federal career civil service. However, he had lost much of his incentive for work. Actually, in the pursuit of a higher position he had gotten into a line of endeavor basically distasteful to him and which had also led into a dead end in so far as further possibility for advancement went. Without detailing the complex dynamics uncovered in the course of prolonged and difficult psychoanalytic study, it might, however, still be noted that his response to this frustration had been a nonconstructive regression to a more dependent position in which he unrealistically waited for "something to happen" which would solve his problems.

As he gained more awareness of his dependency needs, he became better able to deal with them. As one result, he located a position in an area of genuine interest to himself. This constructive step, taken at an optimal point in therapy, provided renewed incentive. The lack of energy and the handicapping fatigue were hastened out of their position of prominence as major symptoms.

Sometimes common usage of the terms fatigue or tiredness helps point out their frequent origins in boredom and monotony. Actually, fatigue is often the outward manifestation or equivalent of boredom, a fact which is reflected by certain every-day expressions. While writing a section of this paper, one of my children came in to tell me she was "tired" of swinging. On suggesting dolls as a substitute, she was "tired" of dolls also. She was not telling me literally that she was fatigued, but that she was bored. In similar fashion, the housewife becomes tired of her daily routine, the salesman tired of making the same sales talk over and over, the 'math' teacher tired of presenting the same theorems, the physician perhaps tired of following his examination routine, and the medical student tired of hearing a lecturer. In each of these instances the use of "tired" refers largely to boredom.

Many persons, particularly those who work largely in occupations requiring physical work, lack appreciation of the fatigue which can follow mental effort and emotional stress. As a result, they may regard an office job as a "soft job" or as a "cinch." Yet the business man knows only too well how fatigued he can become after a "trying day at the office." As another instance, the surgeon may be worn-out after a brief but difficult or hazardous operation. The psychoanalyst may spend 6 to 9 or more hours daily in the same chair. While his physical activity per se is at a minimum, his fatigue at the end of the day may be considerable. The stress incident to competitive endeavor along purely intellectual lines can result in rapid depletion of energy. For persons unacquainted with the fatigue incident to these and similar endeavors, understanding may be difficult. They might be even more surprised to learn of the seeking of physical exercise by a number of the above as an indirect means of rest and as an actual restorer of energy.

Some relations of fatigue, physiology and carbohydrate metabolism. Among the more common misconceptions about energy is the one of the "reservoir" concept in which the use of energy presumably depletes a store which is built up directly by, and proportionate to, the exact amounts of rest and food provided. This mechanical view neglects all the complex factors of motivation, interest, ambition, and the inner personal drives and needs which enter into the supply or lack of available energy. It also fails to take into account the complex ways of emotional dissipation and expenditure of energy. Contrary to the view of a fixed supply of energy as in the reservoir concept, in some instances it appears that the expenditure of energy, particularly psychic energy, sometimes seems almost in itself to stimulate a greater supply or store of available energy.

Medicine has taken careful cognizance of the close interaction of psyche and soma. We have learned much of the physiologic responses to, and the physiologic sequelae of emotions. Although a large field for study and research remains, we have already acquired considerable knowledge about the possible avenues of somatic expression of anxiety and emotional conflict. Some of these have been referred to in earlier articles of this series. Since fatigue is accompanied by some interesting demonstrable clinical findings, it might be worth while to at least mention some of these, particularly the rather typical flat curve seen in the glucose tolerance test and the low blood sugar level with delayed return to normal which may be seen in the insulin tolerance test in certain cases. These are illustrated in the following case.

Case 2. A 24-year-old accounting student was seen in psychiatric consultation because of a simultaneous decline in both class standing and personal health. His principal complaint was his intense fatigue, to which he ascribed his gradual loss of class-standing. There was also considerable weight loss over the previous 6 months, accompanied by anorexia, with a decline from 142 pounds weight upon enrollment in October to 110 pounds in March.

In condensed form the history indicated a submissive and compliant person who was consciously aware of no wish contrary to his mother's suggestions. He had entered accounting on this basis, concealing (even largely from himself) his own contrary interests and desires. However, as he continued in an endeavor in which he was basically not in sympathy, he became less able to repress from awareness his rebellion and distaste. In accord with his major symptoms of anorexia and fatigue, some of his following greatly condensed but verbatim comments are interesting dynamically.

"The work was monotonous and tedious. All my energy was used up. I felt tired and didn't want to do much. . . . A person gets tired from sitting still or from being bored. . . . It's a lot tougher to do something you don't want to do or aren't interested in, and I seem to get tired a lot quicker. When I was in Blake (preparatory school) I was interested and liked what I was doing. I was spry and full of pep. Now I can hardly drag myself around. I feel tired and don't want to do much."

Actually, he was feeling forced to do something he did not want to do and was figuratively and symbolically "fed up." This is reflected in selected quotes from some of his comments about his appetite loss: "I began to feel 'filled up' inside and my appetite went away. I would be hungry in the morning, but after working in the classes awhile, I would get a bloated feeling. . . . I was never hungry during work or after finishing it. . . . I feel better on week ends, but I dreaded even the thought of going back to school on Monday. . . . As Monday comes closer I notice the 'filled up' feeling is stronger."

Careful physical studies by competent physicians had ruled out other possible causes for the weight loss in addition to the clearly present psychologic basis. A glucose tolerance test showed a flat curve with roughly half the expected rise in blood sugar after 30 minutes. Although this type of response is not limited to fatigue states, it is a frequent finding as reported by Alexander[2, 3] and others. A case studied psychoanalytically by Carlson demonstrated the correlation between the glucose tolerance curve and changing emotional status while under psychiatric treatment.[2]

In case 1 an insulin tolerance test also revealed responses which might be anticipated in many cases of severe fatigue, particularly when associated with anorexia and resulting weight loss. Calculating the regular insulin given intravenously at 1/10 unit per kg. of body weight, we found the following results:

1. Fasting blood sugar level	90
2. Thirty minute level.......	28 (very low)
3. Two hour level...........	68 (normally should be back to fasting level)

This test, which may separate adrenal cortical insufficiency from a number of organic causes (e.g., tuberculosis, infections, tumors, histoplasmosis, pituitary dysfunctions, etc.), also indicates the amount of glycogen stored and/or the ability to utilize it. It is interesting in this case in pointing out quite clearly the close interrelation of the psyche and the soma. It seems to me that the important thing here is the simultaneous involvement which takes place, and that perhaps this is of greater moment than arriving at a conclusion as to whether the psychic or the somatic changes are primary or secondary. Actually such dichotomous consideration is unfortunate, and, as Dr. Barton W. Richwine suggested, there is a clear medical need to regard psyche and soma as one unit, together and not separately.

I can find little in the literature at this time in regard to insulin tolerance determinations in fatigue states. Since there are currently few enough laboratory correlations possible between emotional states and altered physiology, further research in this area is clearly needed.

A final point of interest which might be noted here is in regard to the evidence of decreased endocrine activity in fatigue states and in depression. With fear, anxiety, and anger, adrenalin is released with resulting increased pulse rate, deeper respiration, and other associated physiologic changes. With most emotional states the usual response to heightened emotions is increased endocrine activity. The physiologic response is for "fight" or "flight," etc. In distinct contrast, in the fatigue states and in depression there is ordinarily a "psychologic retreat" or withdrawal, with decreased endocrine function toward a state of relative physiologic dormancy. Thus, except in these latter conditions, we can postulate a "primary reaction" of emotional tension in its effect upon the soma via sympathetic-parasympathetic balance and stimulation of endocrine activity. There is likewise a potential "secondary reaction" when the emotional tension itself leads to relative exhaustion or inanition with decreased endocrine stimulation and activity.

The relativity of fatigue. A change of scene, an interesting opportunity for activity, or a sudden new interest may serve to dissipate fatigue. Dr. Charles R. L. Halley pointed out that sometimes the differentiation between work and play may be that work is something you are required to do while play is something you elect to do. In any event, following a long period of demanding work, the student or physician may find his energies considerably revived at an opportunity for what actually involves further expenditure of effort. For instance, he may find himself eager to engage in dancing, bowling, tennis, an excursion, a poker party, hobby, or change of work object. In these instances, with new interests and motivation, fatigue from prior activities may not only recede but it is at times as if the expenditure of effort in the subsequent activity is revivifying and restorative. A good meal or a hot shower can also be restorative in "simple" fatigue.

Sleep is of course a necessity and plays a vital role in both our physical and emotional lives. As discussed elsewhere,[4] 60 to 100 hours of deprivation of sleep leads almost universally to certain abnormal psychologic phenomena. While its vital place is clearly recognized as a necessity, one may perhaps question the establishment of any absolute general requirements or standards as to the amount of sleep necessary for maintaining health. A common standard advocated is 8 hours, although longer and shorter periods have been advanced. However, we know of frequent instances in which people function at a high level of effectiveness and health on relatively few hours of sleep. Edison reputedly slept 4 hours nightly, cramming much of the remaining 20 with very active and highly productive endeavors. Other instances are found in history, biography and my personal experience in which the individual amount of average sleep is low. We know also that recovery time following considerable deprivation of sleep is rapid. This appears to vary little from a maximal 10 to 15 hours of uninterrupted sleep, with seemingly little relation to the length of deprivation.[5-7]

On the other hand, many persons feel a deep need or requirement for 8 to 10 or even more hours of sleep daily. With less they experience subjective feelings of discomfort, lack of energy, fatigue, tiredness, or exhaustion in varying degrees. We are further aware of great differences in sleeping requirements and patterns with the various age levels. The infant sleeps most of the time, whereas the aged person may spend relatively few hours sleeping and his requirements may appear to be less. One may expect that certain psychologic conditioning may exist of the personal attitudes which are present, or that neurotic needs may contribute in some of these instances. However, the actual relation of physical to psychologic factors in these cases and the relative importance of each is a highly individual matter.

Let us consider briefly instances of the inadvertent and unwitting parental contributions to the developing child's attitudes about fatigue, rest and sleep. Occasionally a mother may be heard to say about her child, "He's so tired today," as an excuse for his fussiness, disobedience or temper. This explanation may be true in part or completely, since it is well recognized that fatigue can play such a role. With sufficient repetition and emphasis this kind of comment and attitude can, however, contribute to laying the foundation for a pattern of later excuses or rationalizations for poor performance, noncompletion of tasks or projects, and inadequate achievements.

The child may hear, or perhaps learn to say various things, such as, "Mother says I'm tired; Mother says I need more rest; Mother says I have to have 9 and a half hours of sleep every night to feel well; Mother says I can't stay up late or I won't be able to work; Mother says I must have a rest every day; Mother says I'm the kind of person who must have plenty of sleep; Mother says I can't stand strenuous work."

Gradually the "mother says" part, as the authority, may tend to be dropped and completely forgotten. The original attitudes and admonitions of the mother may become incorporated as an integral part of the child's own self-evaluation. This kind of process is of course a prolonged one and exceedingly more subtle and complex than pictured in abbreviated fashion here. It may be reënfored by the preexisting attitudes and self-appraisals of one or both parents, particularly when they themselves are insecure in these areas and have taken over unhealthily tinged views of their own physiologic processes. In most instances parents are attempting to be protective and helpful. Thus, their possible contributions to psychologically limiting or perhaps less healthful views are largely unwitting. The following example helps illustrate the inadvertent contributions which can be made by a parental figure in the development of attitudes in the child which may in turn play a part in the later onset of emotional illness.

Case 3. A 28-year-old married woman was initially seen in psychiatric consultation because of fatigue, headache and sporadic gastrointestinal difficulties. The fatigue was severe and limiting despite very light household duties. She described her dissatisfactions with marriage, and it became apparent that her husband did not live up to her expectations. This patient was an only child in a wealthy family. Her own mother had few domestic responsibilities and also largely relegated the care of the child to a governess. The mother had moderate hypochondriacal preoccupations herself, slept inordinately, and explained the latter, as well as her decreased attention to the child, on the basis that she had "no time" or was "too tired." She also insisted that the child spend long hours in bed and take daily rests, a routine that was extended into her early teen years. There was later ample corroborative evidence to support a thesis that the child was unwanted. The enforced rests may have represented a way of securing freedom from her child or perhaps control, as well as part of her neurotic overconcern and a projection of her own insecurities about health.

In this case the mother made repeated comments about the child's need to conserve energy and impressed upon her repeated ideas about her lack of physical stamina and her relative weakness. Partly as a result of this psychologic conditioning, the patient had also married her husband partly as an unconscious seeking to find someone who would look out for her and protect her. Her husband was unable to measure up to being the protective figure unconsciously sought. Not only had their entire marital adjustment suffered as a result, but also their sexual adjustment had deteriorated, since she was often "too tired" for sexual relations.

In this latter regard there was regression to a more infantile level of adjustment (a denial of her adult role), punishment of her husband (by sexual deprivation) for his inadequacies, and also certain masochistic elements as well. In this case there was clearly illustrated a close connection between the mother's attitudes toward herself and toward her child, and the child's own later emotional difficulties and limiting chronic fatigue state.

On the basis of some of the foregoing thoughts and similar evidence seen repeatedly in clinical experience, I believe that the relative "requirements" for sleep are very individual and are influenced in important ways by psychologic and developmental personality factors as well as by physical requirements. Ability to perform work, particularly over a long period, relates not only to the physical strength, size, and stature but also importantly to the willingness, to the level of interest, to the personal drive and enthusiasm, and to the personal motivation of the person concerned.

Psychodynamic considerations. Fatigue serves a complex defensive purpose. Unconsciously, out of awareness it attempts to subserve various hidden psychologic needs. These may be divided somewhat according to their depth and relative outward apparentness into so-called "primary" and "secondary" gains.

The "primary gains" in emotional fatigue and in the fatigue states are the deeper and less apparent ones. Hereby the symptoms attempt on a deeply unconscious level the function of denying, concealing or controlling disapproved and rejected wishes or needs. These are largely hostility and aggression but may include repressed sexual drives and other consciously disowned wishes.

The "secondary gains" are more superficial and are often more apparent to the objective, independent observer. Secondary gains may include one or more of the following:

1. Less may be expected or asked of someone who is tired.

2. One may secure some possibly kinder, more sympathetic, or even admiring regard. This includes the gaining of the ego satisfactions or bolstering inherent to being considered a hard worker. Comments may be evoked such as, "Why don't you slow down?"; "Why must you drive yourself so that you get so tired?"; "My, he must be quite a producer," etc.

3. The dependent appeal: The seeking of a more passive position and the avoidance of a

more active one. There may be an implied asking for someone else to "take over."

4. Closely related to number 3 is the delaying of action or decision which may result. Procrastination and avoidance of responsibility may be promoted.

The fatigue contributes to placing its victim in a passive, less responsible position. To the extent this is sought, fatigue and fatigue states are regressive manifestations, attempting unconsciously to regain the dependent protected position of early childhood. The patient says, in effect, "I am tired and weak. . . . I need to be taken care of. . . . Mother will take care of me—and gratify my infantile needs for love and affection which were never satisfied."

Further, the fatigue serves as a way of aiding control and repression of the aggressive rage in response to the frustration when infantile demands are not met. "If I'm weak and fatigued I can't strike out; there is no danger that I will or even can act in response to this repressed rage."

It should be noted that a division of dynamic factors into "primary" and "secondary" is an arbitrary one on my part, one made solely for purposes of convenience in presentation and teaching. One should not lose track of the close and complex relationships which exist between them, nor can one necessarily determine with real precision which is actually first, or more basic, or more vital.

In tracing back the early possible psychodynamic roots, we return again to one possible serious dilemma of early childhood in its needs from, and its attitudes toward significant adults, especially mother or the mother figure. This dilemma, which has been referred to in "The Conversion Reactions" and again in "Depression," relates to handling the hostile aggressive responses to the frustration of infantile dependent needs. The hostile aggression threatens destruction of the object which is at the same time most vitally needed. In the conversion reactions the symptom was intended to reënforce repression and often also secured symbolic gratification of the denied wish. In depression the energy of aggression was finally inverted toward self as a last desperate attempt to deny and conceal the disowned rage and destructive wishes. Fatigue in like fashion can be a manifestation of these basic mechanisms.

The following case is presented to help illustrate some of these points.

Case 4. A 34-year-old man began psychoanalysis because of chronic fatigue and difficulty in concentration. A brilliant engineer when employed, he repeatedly left excellent positions for reasons which he attributed to be the result of his symptoms. He was unmarried and had continued to live at home with his mother During intervals between work he spent his time lying around the house, an occupation in which he was very content.

Actually the lying around the house reflected in poorly concealed fashion his real wish for dependency—to be taken care of. The "secondary gain" here relates to securing satisfaction of his dependency needs, an endeavor in which he was actually (unconsciously) implicitly encouraged by his mother. He says, in effect, "If I am weak and helpless, if I am chronically tired and have trouble concentrating, surely I cannot be expected to be self-sufficient and measure up to adult standards. Mother must take care of me."

In this complex interpersonal situation, the mother through her sporadic sympathy, understanding, and overprotectiveness held out an implicit promise that she might be the all-providing mother. However, this could not realistically be, and on a deeper level of unconsciousness this patient is filled with murderous rage at her failure to literally meet his infantile dependent demands. This placed him in an intolerable position, with his hostility potentially threatening the vital but frustrating mother and also threatening by derepression to come into his conscious awareness. Should the latter happen, the anxiety in prospect appears intolerable, and so all strength must be mustered to reënforce repressive efforts.

The "primary gain" with this patient related to the continued control and concealment of his aggression. Here the patient says, in effect, "I cannot face the realistic needs of an adult world, to work, to strike out independently for myself. I must lie around and be weak and use up my energy restraining, concealing and holding down my rage. The terrific expenditure of psychic energy in this manner of course makes me very tired. Since I am so tired and worn out, there is no energy available for possible acting upon my dangerous aggressive impulses. I cannot do so."

Treatment in this case was successful, although most difficult. The patient no longer suffers from chronic fatigue, has made a reasonably successful marriage, and has maintained a more successful professional life.

In highly condensed form the above dynamics entering into a single, albeit important, aspect of this case have been presented. There is a considerable handicap in including clinical analytic data in such naked form without the vestments of the vast mass of supporting and corroborative data accumulated painstakingly over several years of mutual study and collaborative effort between physician and patient. Yet one has little choice. A detailed presentation would be exhaustive perhaps, but would also prove exhausting. Therefore, if we are to include illustrative cases, there is little choice when dynamics are included but to present them in highly abbreviated form and largely unaccompanied by supportive and confirming data. The reader must be asked to have confidence in the abbreviated clinical material and the dynamics as presented. He must recognize that in each example many hours of painstaking analytic work support the formulations offered.

In many cases fatigue is closely related to depression. Actually, the dynamic formulation can be very similar to that already discussed under "Depression" in the December ANNALS. Fatigue may appear as an equivalent of depression. appear in its place, or be a closely associated manifestation. At times complaints of fatigue are the first subjective manifestation of depression. Bibring[8] has also commented upon the close relationship of fatigue and depression. Complaints of fatigue may accompany or precede clinical depression. Prior to, or concomitant with, the onset of depression, the patient may become exhausted through the expenditure of psychologic effort to maintain repression. When this great amount of energy has been unsuccessfully expended to ward off prohibited impulses, they may then be inverted, with depression the result. The following example illustrates the concurrent presence of fatigue and depression in a case with precipitating situational factors.

Case 5. A young married woman 5 months postpartum sought treatment because of fatigue and depression. Usually vivacious and reasonably energetic, the fatigue had its onset beginning gradually several weeks after the birth of her first child. In her words, "When I wake up, I'm too tired to start the day. Sleep doesn't seem to help at night or during the day. Sometimes I have bad dreams, but when I wake up even from a nap I am apt to feel more tired than when I lay down. . . . I don't care to go out very much any more. (I'm) too tired and (have) little interest. . . .

"Jim is pleased for me to have a maid, and with her doing most of the work I shouldn't be so tired."

In this case the fatigue partly preceded depression but also accompanied it. The arrival of the child served as a situational factor in precipitating the emotional difficulties in a personality adjustment already vulnerable given sufficient initiating circumstances. The patient had hidden unconscious wishes to be cared for herself which made the role of motherhood a difficult, resented, and frustrating one. The conflict resulted in fatigue, but when even this amount of psychic energy expenditure was insufficient, there was inversion of hostility and resulting depression. (See also the discussion of dynamics in the article on "Depression" in the December ANNALS.)

Since these concepts about fatigue resulting from the expenditure of psychic energy can apply in every emotional conflict, the potential is established for fatigue on an emotional basis to be as universal a manifestation as are anxiety and conflict and repression. A considerable expenditure of emotional effort and energy is required to maintain repression. I find an analogy to the boiling teakettle useful. If no vent, or an inadequate vent, is available for escaping steam, it requires an increasingly great amount of effort to contain the increasing pressure. Thus, at times forbidden wishes or drives relegated (repressed) to the unconscious may create pressure (the threat of derepression) which is then combatted by the various psychic forces which can be called upon. Thus, also, any emotional conflict uses psychic energy and can result in fatigue. In other words, we might view emotional fatigue as resulting from a pouring of energy into the repressive forces. By turning the energy inward (as also occurs in depression) the risk to the other person (and to oneself) is less. Here the steam is directed from another vent.

As a ubiquitous manifestation, fatigue may result in varying extent from every situation involving emotional conflict. Some fatigue is likely to be an accompaniment of anxiety whenever present, and a lowered threshold to fatigue is not surprising in any moderately severe emotional illness.

Mention has been made of the fatigue state representing a regressive kind of retreat. Fatigue may also occur, or occur more readily when incentive is lacking or when the chances of reaching a cherished goal appear impossible. We might also bear in mind that the subjective experiencing of fatigue may be affected by various internal "whips" or "spurs," i.e., compulsive drive, fears, anxieties, anger, various "internal" drives and needs, patriotism, love, benzedrine, coffee, and other medical and psychical stimulants. Alexander[9] has also noted that "in a number of male cases there is a conspicuous feminine identification which opposes aggressive ambitious attitudes." In my own experience, however, this has been a very rare psychodynamic factor.

Incidence, clinical picture and diagnosis. The frequency of fatigue as an important presenting symptom in medical practice has been alluded to earlier. Fatigue and exhaustion are likely present in most chronic states of organic disease, especially when there is accompanying psychologic or physical debilitation. However, as Dr. George A. Gray recently pointed out to me, when fatigue occurs solely as a manifestation of organic illness, the latter is by that time generally severe or advanced. Dr. Edward J. Stieglitz reminds us of the fatigue which can follow any kind of pain, particularly when prolonged. Fatigue following pain is related to tension. How frequent is fatigue on solely functional grounds? Diddle,[10] in a study of functional gynecologic disorders, compared the incidence of fatigue as a symptom in a group of patients with no organic disease to a group of controls with and without organic disease. In the first group of 678 female patients he reports complaints of chronic fatigue to be twice as common as in the group of 888 controls.

On the occasion of the presentation of this material to a group of unselected physicians, which included representatives of most of the medical and surgical specialties, they were willing to assist by exploring their experiences with emotional fatigue as seen in their clinical practices and in their own personal experience. These results, given anonymously, are tabulated as follows*:

A. The estimated percentage of my patients in which fatigue is:	*Per cent* 0–25	*Per cent* 25–50	*Per cent* 50–75	*Per cent* 75–100
1. A presenting symptom	13	10	5	3
2. A major presenting symptom	20	5	2	0
3. The principal presenting symptom	25	1	2	0

B. My personal awareness of emotional fatigue (discrepancy between the physical energy used and the subjectively experienced fatigue or the fatigue following emotional conflict):

1. Never	None
2. Occasional	26
3. Frequent	30

The clinical picture is not particularly remarkable. The patient complains of fatigue in varying degrees from mild and occasional to complete exhaustion and inability to perform any kind of work. The patient may be aware of a discrepancy between the actual physical energy used and the degree of fatigue, or he may deny such is the case, in defensive fashion. When the physician determines the existence of such a discrepancy, its presence is almost pathognomonic of fatigue upon an emotional basis.

The fatigue state results from emotional conflict—conflict which may be partly or completely out of the patient's conscious awareness. As we have seen, any emotional state can be fatiguing. Sometimes under mild continuing emotional tension, however, one may also experience pathologic fatigue. This symptom is usually accompanied by a lessened interest in the environment, by preöccupation with the self, by irritability and diminished powers of concentration, and occasionally by depression. A somewhat typical case follows in which a fatigue state has its onset following increased responsibility in a basically dependent person.

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* Assistance in compiling these data is acknowledged to Colonel James Ash and Dr. DeWitt E. DeLawter.

Case 6. A 46-year-old business man was seen in consultation because of symptoms of chronic fatigue, trouble with concentration and attention, and irritability. He was a man of no outstanding talent who had over a 10-year period neither particularly sought nor made much positional advance in his firm. He was basically a dependent personality, content to "get by" and to largely "lean" upon his superiors.

About a year prior to consultation he had been suddenly advanced to a position of considerable responsibility, through reasons beyond his control. Verbally true to our cultural mores of often judging success by achievement of ever higher position, he, at least outwardly, expressed his pleasure with the promotion. As one might expect, these feelings were not unmixed, however. The resulting severe internal conflict had resulted in outward fatigue which interfered with his work effectiveness to a point where (for him) the possible "secondary gain" of a demotion was threatened.

This man appeared listless and tired. He showed little physical or mental initiative during examination and followed instructions in an apathetic and rather compliant fashion. His fatigue was general and more severe in the morning with little improvement with sleep. His interests were diminished but not to the extent often seen in depression. He had given up golf and deserted a square-dance group.

The treatment of fatigue symptomatically by prescribing rest will be doomed to failure if the fatigue results from unrecognized emotional conflicts. Nervous fatigue is characteristically more intense on arising in the morning, with a tendency to lessen or improve as the day passes. This feature leads the patient to sometimes report that "rest does no good" or "I get no good out of sleep." When the fatigue is serious enough to be some incapacity in itself or when accompanied by other emotional symptoms, psychotherapy is indicated. Successful insight therapy will result in the bringing of conflicts into awareness. This allows for more realistic appraisal of conflicting internal needs and wishes and increases the chances for better, more constructive solutions. As the conflicts decrease in number, the fatigue will diminish.[11]

While chronic fatigue can in effect become a character defense (as seen to some extent in case 4), this is not clear enough to warrant separate consideration and study as previously undertaken with the hysterical and depressive types of character defense. The diagnosis of a fatigue state is indicated where fatigue is the most prominent feature of an emotional illness. Although these cases per se are not overly numerous, fatigue itself is a frequent accompaniment of other types of neurotic reaction. The fatigue state is by definition "a psychoneurotic reaction in which the fatigue resulting from emotional stress is the prominent feature."[12]

Differential diagnosis may sometimes be required in debilitating conditions, but in general by the time a physical condition of itself reaches a stage sufficient to produce fatigue the physical condition will probably be rather readily diagnosable. Differentiation from myasthenia gravis will ordinarily offer little difficulty. As Goni[13] points out, the characteristic feature in myasthenia gravis is the rapid fatigability of certain individual muscles or muscle groups. This specific fatigue is unlikely in the more general fatigue from emotional causes. Careful study may be required to rule out early tuberculosis in which fatigue may be an important early feature. One must further be aware of some organic conditions which may also rather specifically produce fatigue, namely, adrenal insufficiency, hypoglycemia, blood dyscrasias, avitaminosis (very rarely), surgical hypoparathyroidism (now very rarely seen), certain cases of unrecognized early malignancy, and hyperparathyroidism. With these at times, and more so in the latter condition, there may be symptoms which can also be regarded as hypochrondriacal.

In conclusion, we can account for the frequency of fatigue on the basis that it can accompany any emotional conflict whether obvious and conscious or hidden and unconscious Fatigue can also accompany severe physical illness. It is influenced by relative interest, motivation, and boredom or monotony. Finally, through the common association of fatigue with hard work there is implicit encouragement in the implied social acceptability of complaints of fatigue.

NEURASTHENIA

A discussion of the psychiatric aspects of fatigue would be incomplete without some consideration of neurasthenia. Near the turn of the century neurasthenia was one of only three categories into which all relatively nonpsychotic psychiatric illnesses were then divided. Hysteria included usually only the major conversion reaction. Psychasthenia included the compulsive states and mild schizophrenia, while all the remaining cases were included under the heading of neurasthenia.[14]

In 50 years the concept of neurasthenia has undergone considerable evolution. Perhaps partly at least, this has been because it served as a kind of diagnostic catch-all, and as a result its use has tended to become less popular. When used currently, neurasthenia may perhaps best adequately be defined as "an emotional disorder characterized by symptoms of physical and emotional fatigue (or) fatigability, irritability, poor concentration, and vague physical complaints."[15]

Etiology. Beard originally proposed the term neurasthenia or "nerve weakness." Freud[16] among others was early concerned with nomenclature and classification in the diagnosis of neurasthenia, and in one of his earliest papers in 1894 proposed separating a group termed the Anxiety Neuroses in which he included many of the manifestations of the anxiety neuroses as currently conceived. Freud early ascribed the etiology of neurasthenia as specifically that of sexual frustration: "Neurasthenia arises whenever a less adequate relief (activity) takes the place of the adequate one, thus when masturbation or spontaneous emission replaces normal coitus under the most favorable conditions."[17] (He had previously cited his view that coitus interruptus was important etiologically.[18]) Freud listed the principal clinical features of his own more narrow concept of neurasthenia as including exhaustion, pressure on the head, flatulent dyspepsia, constipation, paresthesias, and sexual weakness. In the same paper, published in 1896, he notes that neurasthenia "admits of only two specific aetiological factors, excessive onanism and spontaneous emissions."[19] Adolf Meyer later added poor memory and concentration, irritability, poor sleeping, various aches and pains, and increased reflexes as common clinical features.

Subsequently formulations of etiology have undergone substantial development and evolution. Today these earlier constricted and abbreviated etiologic concepts are insufficient. While the symtoms of neurasthenia may well be dynamically contributed to by sexual frustration, there are other complex factors such as the frustration of hostile and aggressive needs, the factors of dependency appeal, the reënforcement of repression and other psychologically defensive endeavors. When masturbation is present, it is now regarded largely as an indication of failure to achieve maturity in this area, and in turn represents a potential source of emotional conflict in itself.

Numerous investigators have undertaken research which has contributed to our understanding of neurasthenia and chronic fatigue as resulting from chronic continuing emotional stress. Among these might be mentioned the classical work of Cannon (on the physiology of the emotions), Selye's work (theoretical constructs re the alarm reaction and chronic stress); and the numerous clinical and experimental observations during combat in the last war (i.e., the observation by the R.A.F. that the incidence of operational fatigue in their pilots directly paralleled the curve of the degree of flying hazard—the danger and deaths *per sortie*). We have also learned of the "let-down phenomena" following strong physical and/or psychological exertion. These phenomena were suspected in the incident of landing accidents of pilots following their return from bombing missions in World War II. Accidents upon landing decreased when by regulation the co-pilot took over the landings upon return.

Careful psychologic research has led to an increasing understanding of the dynamics, some of the principal features of which have been covered under the section on Fatigue and The Fatigue States and will not be repeated here.

The clinical picture. The neurasthenic is more often the individual with a so-called asthenic habitus. He is the tall, slender, often poorly-nourished person with long narrow thorax, neck, and extremities (the ectomorph in Sheldon's classification).

Neurasthenia is a condition that is frequently associated with feelings of failure, frustration, and disappointment. It is often accompanied by feelings of personal inadequacy. The early family situation was far from ideal, most typically a family in which too much responsibility was delegated to the child, and this accompanied by little real parental interest or attention or affection. The neurasthenic is marked by narcissism (from Narcissus of Greek mythology, who fell in love with his image) and the need to be dependent. Characteristic is the easy fatigability following small amounts of physical activity, as though the patient is already so exhausted from the stress and strain of his emotional conflicts that the slightest amount of physical work or activity would prove exhaustive.

The following case of rather typical neurasthenia illustrates the severe level to which fatigue can progress and shows the high degree of therapeutic success sometimes possible.

Case 7. A 36-year-old research chemist was referred for psychoanalytic treatment because of complaints of excruciating, nearly constant headaches, weakness, sexual maladjustment, severe chronic fatigue, and minor somatic complaints. He was tall and thin with a typical asthenic build and imperfect posture.

His fatigability was such that the slightest exertion was completely exhausting. He had reduced his work to 4 hours per day and was on the point of giving it up entirely. During the remainder of his time, which was spent strictly at home, he carefully alternated each 15 to 30 minutes of activity with one-half hour of reclining. These measures were, however, totally ineffective in reducing his fatigue. He experienced progressive difficulty in concentration; and, together with his severe headaches, these symptoms had resulted in an increasingly restricted social life, a situation foreign to his previous nature. Life had become so intolerable that he had been on the point of suicide. He chose psychiatric treatment in what amounted to a last desperate resort, having visited half a dozen physicians in various fields in his search for an organic basis and cure of his terrible symptoms.

This case is clinically rather typical of very severe neurasthenia. This patient, however, proved an apt candidate for intensive treatment and eventually stopped having headaches entirely. His fatigue also regressed, and for over 2 years he has worked full time and has been able to resume his former level of social activity.

The clinical manifestations most frequently associated with cases of neurasthenia may be listed as in table 1.

The fatigue and easy fatigability observed is a chronic type of fatigue in which rest and sleep do not refresh. The fatigue is typically greatest on arising and improves during the day's activities. Physical exercise may actually bring relief as was observed during the war by the R.A.F. Ferenczi[20] described a series of cases which present marked symptoms for one day and are termed by him "One-Day Neurasthenia." After Freud he ascribed a purely sexual etiology.

Diagnosis. As suggested earlier, the diagnosis of neurasthenia is made more rarely today than previously, with a tendency in certain quarters for it to fall into relative disuse. If this diagnosis is to be made, it is properly done in the presence of a number of the more characteristic symptoms as tabulated. Where usage and preference result in the rare use or discard of the syndrome, the diagnosis of Fatigue State is used or, in the absence of fatigue as the major manifestation, the selection of the next most suitable diagnostic category among the psychoneuroses is made.

One must be careful to differentiate psychoneurotic reactions (in which fatigue is a prominent feature) from organic syndromes which simulate neurasthenia. Hypochondriasis, with its lowered activity and decreased initiative, may be confused with mild neurasthenia. Actually, the error in diagnosis in this instance is apt to be more frequently the other way around with the fatigue reaction being diagnosed as hypochondriasis.

Cerebral arteriosclerosis may be the cause of a neurasthenic-like pattern; so, too, may occasional cases of general paresis, brain tumors, depressions and early schizophrenia.

The following case illustrates occasional problems in diagnosis and the poor prognosis to potential treatment as the result of early misdirected therapeutic attention.

Case 8. A 26-year-old single woman was referred for psychiatric consultation by an internist for symptoms of a neurasthenic nature. Having "inherited" the case from a colleague who had moved to another part of the county, he had become concerned at the nature of her treatment regimen. On the basis of a slight depression of the BMR, a diagnosis of thyroid deficiency had been originally made 6 years previously. She had been placed on daily thyroid on a constant basis with gradually increasing doses until she was currently taking 10 grains regularly every 2 days. In addition to various other more sporadic medication, she was daily also taking from 2½ to 7½ or more mg. of benzedrine.

Careful diagnostic study had convinced the internist that there were more deeply seated reasons for her symptoms. There were indeed, as he had accurately suspected, adequate psychologic factors in evidence to account for her symptoms on an emotional basis. The establishment of the diagnosis (although erroneous) and the resulting treatment had encouraged unhealthy narcissistic preoccupation with her physical self and functions. The relationship with the physician had also inadvertently helped in iatrogenic fashion to meet her strong dependency strivings. All of this unfortunate history had vastly complicated the original fatigue state. After years of focusing attention on what had been regarded as possible physical aspects, it proved a most discouraging task to try and secure her interest belatedly in the exploration of emotional conflicts as the real major factors of her illness. Her orientation was too fixed to permit adequate psychotherapeutic study and it is unfortunately likely that she may never be amenable to the only treatment that can offer real hope in possible relief of her symptoms.

TABLE 1

*The Principal Features of Neurasthenia**

Psychologic Features	Emotional Features	Physical Features
1. Dependency	1. Difficulty in concentration	1. Fatigue, fatigability, weakness, and lack of energy
2. Narcissism	2. Irritability and tension	2. Headache: (a) pressure or weight, (b) band, (c) suboccipital
3. Hypochondriacal tendencies; somatic and functional preoccupation; mild to moderate, sometimes shifting	3. Memory may function poorly; may appear impaired	3. Asthenic body build, blood pressure low, coldness and perspiration of extremities frequent
4. Regressive retreat	4. Feelings of inferiority; social interests reduced	4. Insomnia and weight loss
5. Underlying emotional conflict	5. Gloomy, pessimism, depression, apathy; suicidal ideas may be present	5. Fleeting and shifting somatic symptoms; indigestion, heart burn, anorexia, dizziness, muscular soreness, tachycardia, constipation, flatulence, pain in the abdomen, etc.
6. Primary and secondary psychologic gains (outlined earlier in the section on psychodynamics of Fatigue and Fatigue States)	6. Lack of initiative and ambition	6. Reflexes may be increased but are ordinarily equal
7. Depressive features may accompany marked fatigue	7. Sensitive or "thin-skinned"	
	8. Impairment of sexual function—seldom is ability adequate or relationship satisfactory	

* As modified from ref. 11, page 146.

TREATMENT

The treatment of choice in the fatigue states and in neurasthenia is psychotherapy. Results to be expected with the interested coöperative patient working in active collaborative effort with a well-trained psychotherapist are very good. Ordinarily, the deeper and more insight developing is the therapy, the better are the prospects for significant and permanent constructive change.

Fatigue invites approaches by the more common measures usually associated with the alleviation of physical fatigue. Recommendations by physicians, more frequently in decades past, have included changes of avocation and work, adopting a hobby, increased rest and sleep, a vacation or trip, high-caloric diets, changes in level of responsibility, physical therapy, various types of medication, including vitamins and hormones, reassurance, and suggestion. Various ones of these measures or regimens of combinations of them have been endorsed or advocated at various times.

The interested and sympathetic physician can indeed secure some improvement simply by devoting time and attention to a patient with or without one or more of the above as adjunctive measures. This type of response to genuine interest and attention is, however, a temporary one. As long as the crutch-like supportive nature of some of these measures is clearly recognized, the physician will not depend too much upon results continuing, and both he and the patient will avoid disappointment. Also, harm is less likely from the inadvertent promotion of further dependence, which can be terribly and permanently damaging through its rendering some patients less amenable or even permanently non-amenable to psychotherapy. By inaccurate focusing on physical aspects it is possible to "fix" a neurotic pattern. The aim, of course, should ultimately be for psychotherapy in all cases where available and feasible, and particularly in cases where there is real interference in living.

Cases to be referred for intensive psychotherapy and psychoanalysis should be carefully selected as to actual or potential interest, reasonable intelligence, and ability to coöperate. This treatment approach is difficult, time-consuming, and expensive. Results, however, when psychoanalysis is effective, are well worth all the efforts required. At the beginning no definite promises can or should be made by the consulting analyst as to the duration, nor should specific results be promised. Many therapists begin treatment on a trial basis of a month or so for both physician and patient.

In general, dietary measures, manipulation of the external environment, pharmacologic measures, reassurance, rest or suggestion can achieve little more than temporary respite or improvement. Emotional fatigue is due to internal conflict. As Alexander[21] advocates, "Such cases require a consistent psychotherapeutic approach." The basis of the conflict must be uncovered, recognized, brought into conscious awareness, and dealt with constructively for its successful resolution.

S. Weir Mitchell, a psychiatric pioneer in America, treated neurasthenics with great success many years ago with a regimen of enforced rest and high-caloric diets. His ability to gain improvement (which, however, was often followed by relapse upon discontinuance) was the result of his own dynamic personality, plus the gratification of the dependency needs of the patient as an unwitting means to his therapeutic ends. Actually, however, his regimen abetted and encouraged the neurosis instead of really relieving it. Neurasthenic patients need to become aware of, and to learn about their unconscious dependency needs and strivings and need to be willing to renounce some of them if real and permanent improvement is to be secured and a higher level of maturity is to be achieved.

At times, electric shock and various physical methods of treatment or drugs are used in treating fatigue reactions. These are not recommended. The end result will only too often be unfavorable because of the fundamental features of this group of emotional reactions (marked by dependency, narcissism, and hypochondriasis). In order to obtain satisfactory permanent results with the fatigue reactions, the therapist must be aware of the above personality pitfalls and help the patient avoid them. One must keep in mind that anxiety is potentially or actually present in the fatigue reactions but is largely kept under control or concealed. The outward manifestations of fatigue are present in place of the outward manifestations of anxiety as seen in the more overt anxiety reactions. The aim of the therapist is to secure insight and to promote greater emotional maturity, as is true for all psychotherapeutic endeavors. Since personality development beyond the narcissistic level has been retarded or interfered with in these patients, they must be encouraged to progress and mature to a more adult and constructive level of integration.[22]

Sharpe[23] has discussed the significance of fatigue appearing during the course of analysis. She relates this as a prelude to the impending appearance in dreams or consciousness of affective memories, i.e., essentially fatigue from the intrapsychic struggle over derepression. The recognition by the therapist of the absorption of energy in intrapsychic struggle during phases of resistance can be useful in therapy.

In the treatment approach of intensive psychotherapy one attempts to learn as much as possible about the patient and what makes him "tick" as a person. Interest is centered upon his emotional life, his satisfactions, his goals, and particularly upon his personal relationships with, and adjustments to other people. One is particularly concerned with the vicissitudes of all important interpersonal relationships, past and present. Inevitably, the one relationship available for laboratory level study, observation, and dissection is that with the therapist, and this offers an excellent area for gaining understanding. Inevitably, also, patterns of reaction, skills and technics in dealing with people thus far will be employed in the relationship with the therapist.

Although attention is focused on the present day-to-day living and minute-to-minute observations of thoughts, feelings, physical sensations and associations, these often lead into emotionally significant areas of the past and to greater understanding of early problems and how these were handled. As we have seen illustrated repeatedly in case material to date, the vicissitudes of the very early childhood relationships with significant adults are most vital to the later potentials for emotional health.

With such an intensive study, usually requiring hundreds of hours of work over several years, we may aptly compare psychoanalysis to a complete course of graduate study in a university where the subject of the course is the patient, who also becomes the reference source and textbook for all primary data. The undertaking of this kind of treatment is indeed a serious matter, not to be undertaken without serious prior considerations on the part of both physician and patient.

SUMMARY

In the psychiatric aspects of fatigue an attempt has been made to present various descriptive and clinical data, together with some of the basic dynamic concepts concerning emotional fatigue, the fatigue states, and neurasthenia. In the introduction, the frequency with which fatigue occurs was pointed out, as was the tendency for general social approval and acceptability of this symptom. Fatigue was subdivided into mental, physical and emotional types of fatigue.

In discussing the fatigue states, emotional fatigue was described as fatigue which is out of proportion to the apparent or known stimulus. The relatively high incidence in medical practice was mentioned, as was its relation to interest, motivation, incentive, and boredom. Brief mention was made of some physiologic relationships, including carbohydrate metabolism, together with some indications for possible useful research in this area. The relativity of fatigue brought us into brief consideration of such factors as hobbies, new activities, and rest. Variable individual physical and psychologic needs for sleep were discussed.

Noting some possible inadvertent parental contributions to self-attitudes about sleep, strength and health then led us into a brief survey of some psychodynamic considerations in emotional fatigue and the fatigue states. A concept of "primary" and "secondary" gains was offered, while recognizing the arbitrary line of division in view of close interrelationships between the two. The importance of control, concealment, and the reënforcement of the repression of unconscious, forbidden, aggressive and hostile or sexual strivings was described

as the primary goal or gain. On the other hand, the principal dependency needs and ego-building or supportive needs were included as secondary and more outwardly apparent goals. The close relation of emotional fatigue to depression was noted.

The clinical picture and diagnosis of emotional fatigue and the fatigue states were outlined. Neurasthenia was studied with a brief historical sketch of the original broad concept gradually narrowing considerably. Etiology was also noted to have undergone evolution from an earlier almost mechanical and automatic response to certain sexual events to more complex dynamic origins. With the clinical picture, an outline table of symptoms was presented, and factors in diagnosis were briefly considered.

Treatment was presented with an outline of the usual superficial and supportive measures and some considerations involved in the deeper therapy of the psychoanalytic approach. Comments included about treatment are to be considered in supplement to those made in previous papers of this series. Eight cases have been presented in clinical illustration of various points. As in the other articles, medical discretion has resulted in the alteration of any identifying data included, to prevent any possible identification of actual persons.

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President's Page

GRIEVANCES INVOLVING PHYSICIANS

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Herbert P. Ramsey

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Hugh H. Hussey, M.D., *Chairman, Program Committee*

Professor and Head of Department of Preventive Medicine and Public Health, Georgetown University School of Medicine

SEMINAR ON DISEASES OF THE LIVER AND BILIARY TRACT

Franklin M. Hanger, M.D.

BILE FORMATION; THE PHYSIOLOGY OF JAUNDICE (20 minutes)

Peter D. Comanduras, M.D.

Associate Clinical Professor of Medicine, George Washington University School of Medicine

INFECTIOUS HEPATITIS (20 minutes)

Irving Brick, M.D.

Assistant Professor of Medicine, Georgetown University School of Medicine

DIFFERENTIAL DIAGNOSIS OF JAUNDICE: AN INTRODUCTION (20 minutes)

Franklin M. Hanger, M.D.

CASE PROBLEMS (30 minutes)

Harold Jeghers, M.D.

Professor of Medicine and Director of the Department of Medicine, Georgetown University School of Medicine

Jack J. Rheingold, M.D.

Associate in Medicine, George Washington University School of Medicine

Alec Horwitz, M.D.

Associate Clinical Professor of Surgery, George Washington University School of Medicine

QUESTIONS AND ANSWERS (20 minutes)

WEDNESDAY EVENING, FEBRUARY 17, 8 P.M.

II. PORTAL HYPERTENSION

THE PORTAL CIRCULATION; MECHANISMS OF ASCITES (20 minutes)

Major Edward J. Jahnke, Jr., M.C., U.S.A.

Chief, Vascular Surgery Section, Surgical Service, Walter Reed Army Hospital; Staff Member, Division of Surgery, Army Medical Service Graduate School

HEMATEMESIS IN PORTAL CIRRHOSIS (20 minutes)

Lt. Colonel Eddy D. Palmer, M.C., U.S.A.

Chief, General Medical Section No. 3, Medical Service, Walter Reed Army Hospital

DIFFERENTIAL DIAGNOSIS IN ASCITES (20 minutes)

Franklin M. Hanger, M.D.

CASE PROBLEMS (30 minutes)

George E. Schreiner, M.D.

Instructor in Medicine, Georgetown University School of Medicine

John Parks, M.D.

Professor of Obstetrics and Gynecology, George Washington University School of Medicine

Wallace M. Yater, M.D.

Director, Yater Clinic

QUESTIONS AND ANSWERS (20 minutes)

THURSDAY EVENING, FEBRUARY 18, 8 P.M.

III. SYMPOSIUM ON THERAPY

AN OUTLINE OF THERAPY IN DISEASES OF THE LIVER AND BILIARY SYSTEM (20 minutes)

Franklin M. Hanger, M.D.

MEDICAL THERAPY IN HEPATIC DISEASE (15 minutes)

Gerald B. Phillips, M.D.

Clinical Investigations, National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Public Health Service

MEDICAL THERAPY IN BILIARY TRACT DISEASE (15 minutes)

Thomas S. Sappington, M.D.

Associate in Medicine, George Washington University School of Medicine

TREATMENT OF HEMOLYTIC JAUNDICE (15 minutes)

Charles E. Rath, M.D.

Assistant Professor of Medicine, Georgetown University School of Medicine

INDICATIONS FOR GALL BLADDER SURGERY (15 minutes)

William S. McCune, M.D.

Associate Clinical Professor of Surgery, George Washington University School of Medicine

INDICATIONS FOR PORTA-CAVAL AND OTHER SHUNTS (15 minutes)

Charles A. Hufnagel, M.D.

Director of Experimental Laboratory in Surgery, Georgetown University School of Medicine

QUESTIONS AND ANSWERS (20 minutes)

Editorials

THE ART OF MEDICINE*

Medicine is composed of a very careful blending of two basic elements. One is the science of medicine, and the other is the art. To my way of thinking, unless this potion (the practice of medicine) is blended in proper proportion, the end-results are not as good as they might be.

What is the science of medicine? The science of medicine is that broad stream into which many tributaries have poured scientific knowledge. Link after link has been forged in the chain of scientific medical progress. This progress is handed on to the individuals who follow. I as a professor of surgery may develop certain technics which can be passed on to my successor. Sir Alexander Fleming developed the great antibiotic rootlet that has now grown into the broad spectrum of antibiotic therapy, and on the foundation he has laid others can build stone upon stone. This is purely a mechanical thing; the science of medicine is the mechanics. In other words, an individual can carry out diagnostic and therapeutic procedures without the art of medicine ever touching him. Take a patient with hyperthyroidism. You can have a basal metabolism test and blood iodine determination run on him and finally give him radioactive iodine with control of the thyrotoxic symptoms. This is purely the scientific part.

Now what is the art of medicine which must run hand in hand with the science in order to develop a pure type of medical practice? The art of medicine is that which is envisioned as the physician-patient relationship. The art of medicine is not handed down from the professor to his student as is the science of medicine. One cannot lay a foundation in the art of medicine upon which the next individual can build. The art of medicine must be learned anew by each neophyte who accepts the practice of medicine as his vocation. The art of medicine is like the art of painting. The great painter who paints on the canvas cannot simply, by handing down a formula, transmit the ability that he has to depict on the canvas a scene which he sees in life. When the artist dies, enshrouded with him goes the art which he developed during his lifetime. And so in medicine, the art of medicine is a factor which each neophyte must learn anew, and which, to my way of thinking, is an extremely important part of the total practice of medicine. Actually, in the early days there was a great deal of art and not too much science. Now we have tipped the scales the other way, and there is a great deal of science but not enough time for art.

What has happened to the art of medicine? As soon as the day came when no one individual could cover the whole spectrum of medicine it was natural that medicine would become fragmented and fractionated. So we developed specialization, and I certainly do not decry that development. However, with that came a fractionation, so that we began to think of the individual as a physiologic or anatomic complex. We began to speak of Mrs. Jones not as Mrs. Jones the patient from Podunkville whose husband has been so and so, and has five chil-

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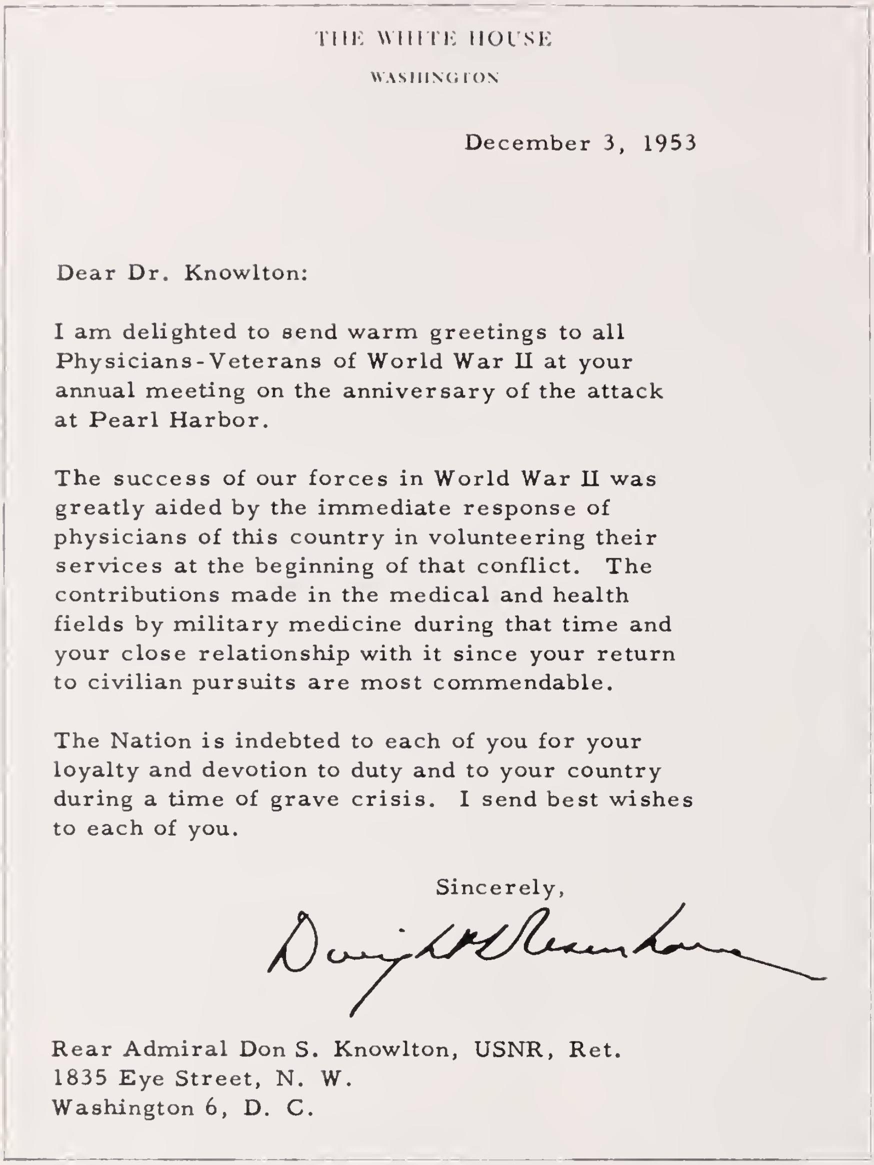
*This is a portion of the address Dr. Casberg delivered before the students of George Washington University School of Medicine at the opening of the 130th Academic Session, September 21, 1953.

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia.



THE WHITE HOUSE
WASHINGTON

December 3, 1953

Dear Dr. Knowlton:

I am delighted to send warm greetings to all Physicians-Veterans of World War II at your annual meeting on the anniversary of the attack at Pearl Harbor.

The success of our forces in World War II was greatly aided by the immediate response of physicians of this country in volunteering their services at the beginning of that conflict. The contributions made in the medical and health fields by military medicine during that time and your close relationship with it since your return to civilian pursuits are most commendable.

The Nation is indebted to each of you for your loyalty and devotion to duty and to your country during a time of grave crisis. I send best wishes to each of you.

Sincerely,

Dwight D Eisenhower

Rear Admiral Don S. Knowlton, USNR, Ret.
1835 Eye Street, N. W.
Washington 6, D. C.

dren; no, we speak of Mrs. Jones as the peptic ulcer case in bed 49. We seem to be drawing completely toward the scientific side and neglecting the art of medicine. The art of medicine is not just hocus pocus. It is the dispensing of medicine with an element of human warmth, with a personal interest, and in the long run it brings about better therapeutic results. The art of medicine is not just an accessory; it is an essential part of the dispensing of medicine. Not only must the right medicine be selected and the prescription accurately filled, but it must be given in the proper way.

What has given rise to this change of emphasis besides the fractionation of the human patient due to the development of specialization? Briefly, all of the educational system, to my way of thinking. Our educational system is getting more and more pragmatic. We are not thinking in terms of educating the student to become a broader thinker, and to give him a broader base for getting along in life; education is pointed toward a degree. All of the fringe benefits we might need are trimmed off to streamline the educational process of getting a degree, which immediately, whether it is a law degree, a medical degree or some other degree, we weigh on the scales against an annual income. Possibly I am overcritical; perhaps I am wrong, but I don't think I am. Even our high schools are getting to be extremely technical in their development. Anything that can be proved in a test tube or by a mathematical formula on the blackboard is right. Anything that can't—well, it may not be wrong, but certainly it is not as sound as what is proven on the blackboard or in the test tube.

We seem intent on becoming a practical, pragmatic nation, and that part is wrong. I am not decrying scientific growth and gadgetry.

I use gadgets and love them, but I am saying that with scientific development we must have a philosophy that goes along with it. The reward of the physician who practices the art of medicine, I hardly need to relate to those who practice it. The most satisfying reward one gets as a physician is not necessarily financial, but the respect of one's patients and one's community. It is the practice of the art which develops that respect. Interest in your patient should extend beyond the fact that an antithyroid tablet will cure his hyperthyroidism.

I should like to sum up what I have tried to say by quoting a Persian poet, who lived many centuries ago. Translated into English, this Persian poet so spoke:

> "Shoulds't thou then repair to thy larder and there of thy once bounteous store find but two loaves of bread remain. Yet would I counsel thee, to sell one wherewith to buy white hyacinths to feed thy soul."

Melvin A. Casberg, M.D.
Assistant Secretary of Defense
(Health and Medicine)

ANCILLARY COVERAGE BY MEDICAL SERVICE

Among the many patients who have come under the Blue Shield–Blue Cross banner are increasing numbers who could not meet rising medical costs from current income. The creation of a source of payment to hospitals and physicians from these low-income patients has been a most pleasing aspect of the movement. The opportunity to make small, regular prepayments not only elevates these people into a position where they can contribute individually to the medical expense of the community, but also provides them with a sense of dignity which helps to establish them as better citizens.

Whenever a fund established to meet specified medical expenses reaches a state of adequate reserve the tendency is to make excessive demands upon it. Its very adequacy invites abuse. Patients may actually receive far greater service than would ever have been sought under a system of individual payment. In certain cases the physician may tend to order more ancillary procedures for patients with Medical Service coverage than if the patient were making direct payment. Such orders may be left unrestrictedly in the hands of a house officer with the feeling that the cost of such services is of no concern to the patient.

Such problems are close to the fundamentals of insurance practice. Predictable utilization of the plan's resources depend upon payment being made only for ordinary medical services. Unplanned or indiscriminate loading of costs may throw Medical Service out of financial balance and require adjustments leading to damage of our basic objectives. Our rates must be kept within reach of the low-income patient, who is in most need of help.

What may be early indication of a trend to provide unusual supporting services is a recently appearing group of high cost laboratory cases. Since early summer we have received occasional claims for laboratory procedures costing up to $2,000.00 for a single case. In our plan all ancillary services are considered to be the practice of medicine and as such are covered by Medical Service. There has been no ceiling on legitimate laboratory or X-ray charges. Our contract clauses on multiple procedures and the requirement that only those tests are covered which are directly related to surgery or obstetrics are being studied as possible safeguards at present.

However, the plan to extend medical coverage and the general agreement that backsliding restrictions should not be invoked suggest the need to enlist the aid of the profession in keeping claims at reasonable levels. It is believed that investigative and teaching requirements must be financed outside the plan. All participating physicians have a stake in the solution to this problem.

D. S.

PSYCHIATRIC CLINIC SERVICE THROUGH COMMUNITY INITIATIVE

The scarcity of psychiatric clinic service to children becomes more exaggerated as the demand for such service increases. The demand increases as the informed community realizes that some 5 per cent of children in secondary schools are so emotionally disturbed as to be in need of professional psychiatric help. Psychiatric clinic facilities for children in Washington, D.C. are far below minimum needs, and still the requests of the Bureau of Mental Hygiene of the Department of Public Health for more funds to increase psychiatric clinic service are denied.

The lack of adequate psychiatric clinic services in the community has led the Superintendent of Schools of the District to consider the establishment of some psychiatric facilities within the school system itself. Whether these would be only diagnostic and educational or whether therapy should be included is not completely clear at present. In some metropolitan centers most psychiatric clinic services to children in public schools are given under auspices of the Health Department, while in others such service is given through clinics operated under auspices of the Department of Education and the Superintendent of Schools.

An interesting plan for psychiatric clinic service to school children in one section of Southeast Washington was begun in January 1952, when the Kiwanis Club of Eastern Branch, D. C. agreed to provide the professional staff for a clinic to serve students of the Sousa and Kramer Junior High and the Anacostia Senior High Schools. Students are referred to this Kiwanis Clinic by the school principal with the written permission of the parent or guardian. Clinic service was enthusiastically received by the school administration, teachers and parents alike. Clinic service has been gradually expanded so that the clinic now has three principal functions: first, the case work, psychologic and psychiatric examination and diagnosis of students referred; second, treatment service to selected students, principally through individual psychotherapy; and, third, an educational program for teachers and counselors.

The clinic operates in the Anacostia High School two evenings a week throughout the school session, one evening for the diagnostic section and one evening for the treatment section. The professional staff has been gradually expanded through recruitment from the staff of Saint Elizabeths Hospital and from the community, and much of these professional services have been donated to the clinic as a community service. This is a fine example of unselfish and devoted service by professional people.

At present the regular clinic staff consists of 7 psychiatrists, 4 clinical psychologists, 3 psychiatric social workers, 3 registered nurses, and 3 secretaries. In addition, there are 2 consultants in child psychiatry and 2 consultants in neurology.

The success of the Kiwanis Clinic has stimulated a great amount of interest on the part of local professional and lay groups alike, with a view toward the establishment of similar clinics in other areas of the city. Such a probability is somewhat remote, due to the lack of the unique components of success which were utilized by the Eastern Branch Kiwanis Club, namely, (1) members who were also psychiatrists interested in clinic service; (2) the nearness to the Saint Elizabeths Hospital civic-minded professional personnel; and (3) the decision of the Kiwanis Club that psychiatric clinic service was a vital need in the community. In a few cities psychiatric clinics have been organized under the auspices of church groups or parent-teacher associations, but it is believed that this is the first time a psychiatric clinic has been set up through the efforts of a men's service club.

The work of this new psychiatric clinic venture will be watched carefully by the local school authorities and by other interested groups, for it may be the forerunner of tax-supported psychiatric facilities within the public school system in Washington.

ADDISON M. DUVAL, M.D.

MONTGOMERY COUNTY CRIPPLED CHILDREN'S TREATMENT CENTER

Among the trends of modern medical practice is the increased concern for rehabilitation and restoration to maximal activity of those afflicted with disabling illnesses or physical handicaps. It has long been recognized by physicians that responsibilities to patients continue beyond the acute stage of disease to the attainment of optimal health and well-being. With advances in knowledge on all fronts of medicine, particularly orthopedics and physical medicine, it is becoming increasingly possible to discharge these responsibilities. Not the least of the influences supporting these efforts has been the work of voluntary health organizations such as the National Society for Crippled Children and Adults, National Foundation for Infantile Paralysis, National Tuberculosis Association, and others. In the metropolitan area of Washington, with its excellent medical facilities, there is ample opportunity for these agencies to develop to maximal usefulness.

The Montgomery County Chapter of the Maryland Society for Crippled Children and Adults is one of many such organizations attempting to meet the needs of the handicapped in this area. Working in close conjunction with private physicians, the County Medical Society, and the County Health Department, it is operating a Treatment Center at the American Legion Post 105 Building, 1206 Rockville Pike, midway between Bethesda and Rockville. This center was established to supplement diagnostic clinics in orthopedics and speech held monthly in Sandy Spring and Rockville under the auspices of the County Health Department and private physicians. Cases are accepted upon written referral from physicians, schools and the County Health Department, who are kept currently informed of the progress of the patient. A minimum fee is stipulated, but no case is refused for inability to pay. Since its establishment a year ago over 1,000 treatments have been given.

A graduate therapist gives corrective speech treatments, Mondays through Fridays, and another graduate therapist offers physical therapy on Wednesday, Thursday and Friday. Speech therapy includes treatment of problems in articulation, stuttering, and those due to cleft palate, aphasia or deafness. With the aid of a shoulder wheel, bicycle restorator, parallel bars and a walker, physiotherapy is offered for cases of residual poliomyelitis defects, postoperative conditions, hemiplegia, cerebral palsy, fractures and amputations.

Physicians whose patients reside in Montgomery County will find the Treatment Center conveniently located. Appointments may be made by calling Olympic 9-9191.

In perhaps no other branch of medicine are the rewards to the community and the individual as great as in rehabilitation. A stuttering child helped to speak correctly, a speech defect alleviated, and the improved function of an impaired limb are the benefits of correct medical diagnosis and persistent skilled therapy.

AUSTIN B. ROHRBAUGH, M.D.
Medical Advisor, Treatment Center;
President, Montgomery County Medical Society

In and Out of Focus

BY THE OBSERVER

"Look Again, Doctor!"

Doctors can hardly be blamed if they become weary of being told what is wrong with them and what they must do to win friends for themselves and their profession. Much of what has been said on this subject has been repetitive and, in your Observer's opinion, somewhat dull. Happily, there are exceptions, and the 75-minute symposium on "Look Again, Doctor!" which was presented in the auditorium of the Medical Society Building on November 4, 1953, is in this category. He cannot recall an instance when criticism and advice have been served more palatably. It was apparent to your Observer that the audience, consisting of doctors and their wives, thought so too.

Credit for this entertaining and informative symposium goes to Dr. Hugh H. Hussey, Chairman of the Program Committee, and to Dr. Josephine E. Renshaw, Chairman of the Committee on Public Information. Both of these physicians have displayed considerable originality and intuitive understanding of what appeals to doctors and, in this instance, their wives.

For the benefit of those who, for one reason or another, were not present, this month's column is devoted to excerpts of the remarks of participants in the symposium. Lack of space prevents publication of the complete talks but the salient points made by the speakers will indicate why this program was such a success.

★

"—Your Office—"

All of us have had the experience of returning home after a long absence and seeing familiar surroundings in an entirely new and sometimes disillusioning light. Things that had escaped our notice were so apparent that we wondered how they went unnoticed; why had we not observed the frayed upholstery, the faded drapes, and the discolored walls? The explanation is obvious: We had become so accustomed to our surroundings that their deterioration had not registered with us.

This also happens in the doctor's office, and too frequently nothing is done about it. He soon drifts back into his routine, and the disorder, the dog-eared magazines, the unattractive furnishings, the worn and rickety furniture again go unnoticed. But patients do observe and, understandably, some of them wonder. Their comments are frequently far from complimentary.

Dr. Paul Jaquet, Jr., the young Washington internist who opened the symposium, not only observes his surroundings with a critical eye but does something about them. His topic was "Have You Looked at Your Office Lately?"

> "Physicians, no less than their wives," he said, "are often influenced by first impressions. From rather careful observation of physicians' offices over the past several years, I have been motivated sufficiently to inquire, 'Why do so many of us ignore the marvelous opportunity of making that first good impression in our offices?'
>
> "The new patient usually arrives in our waiting room with a mixture of fear, apprehension, self-consciousness, and often downright panic. He usually has to wait. This waiting period, though often carried to excess, affords a critical time of inspection which will result in some impression being gained. How unnecessary that it be anything but favorable!"

Dr. Jaquet then proceeded to make definite suggestions.

> The waiting room should be cheerful but not garish. Restful colors in drapes, slipcovers, rugs, as well as for walls and furniture are recommended. Plants and a 10- or 20-gallon aquarium stocked with tropical fish also brighten an office and make waiting much pleasanter.
>
> Furniture should be arranged so patients do not face one another. Some find the opposite arrangement disagreeable.

Large wall mirrors enhance and emphasize the beauty of the office.

Soft music from a standard or FM radio tuned in on a good music station or piped-in music helps soothe disquieted patients.

If rooms are small, a quiet exhaust system may be necessary.

Indirect lighting is preferable to ceiling fixtures which "glare down upon the patient."

Comfortable and convenient surroundings for the secretary are essential.

Muffled telephone bells and a good buzzer signal system do much to keep the office operating quietly.

The efficient operation of the office is also facilitated by a telephone-intercom system. It will save the physician and his assistants many unnecessary steps.

These are, in Dr. Jaquet's opinion, some of the essentials of a smoothly conducted and pleasant office.

★

"Patients Are People"

Perhaps the most frequently heard criticism of physicians is that they have become impersonal in their relations with patients. Medical leaders and others in the medical profession who have spoken on this subject have not hesitated to admit that to a considerable extent this is true. Among the major reasons given are overemphasis on science to the exclusion of the art of medicine, and specialization.

Dr. Josephine E. Renshaw, whose topic was "Patients Are People," is one of those who is inclined to go along with this view. People, she said, are asking, "Where is the old family doctor?" Dr. Renshaw contends that it is not the old family doctor people want but his sympathy and understanding.

She urged that whenever the opportunity offers, even when the patient comes in for routine examination, doctors not overlook the importance of the human touch. There are procedures in such examinations which, she said, "shock the patient's dignity. The experience is frightening to him." This could be minimized by doctors if they would take the time to explain the reasons for the procedure and what the trouble is. If this were done, she said, "patients won't be running off to look up their troubles and cures in magazines."

★

"—Other Doctors"

The deterioration in relations between physicians has been cause for deep concern among thoughtful observers in the medical profession. For upon mutual respect and friendliness rest not only stability but the very existence of medical practice as it is known today.

What then are the disturbing factors in this situation? These are set forth eloquently by Dr. Zigmond M. Lebensohn, whose topic was "What You Owe Other Doctors." Emphasized by him is the tendency among physicians to make disparaging remarks about their colleagues. Sometimes this is due to thoughtlessness; at other times, to put it charitably, it is done with unkind intent.

Equally to be deplored, Dr. Lebensohn said, is the neglect of the amenities of medical practice, such as a physician's failing to inquire if a patient has recently been attended by another doctor and, if so, if he has discharged him. In the latter event, it is only courteous for the physician to call his colleague and tell him that the patient has come under his care. However, this is done so seldom that a physician who received such a call would, to say the least, be astonished.

Pointed out too was the physician's failure to recognize that he is not only obligated to adhere to the Principles of Medical Ethics but to conform to the customs in the community. Equally important, he is expected to show good taste in his professional activities.

These and other facets of this problem are dealt with by Dr. Lebensohn. His remarks were considered so timely and important that they are published in full on page 51 of this issue of the MEDICAL ANNALS.

★

"'A Soft Answer—'"

Your Observer can well understand the feelings of the weary doctor or his harassed secretary when on particularly trying days they are deluged with telephone calls. The temptation is to give vent to their irritation either by being coldly impersonal or abrupt.

Under such circumstances the telephone can become a destructive instrument, destroying in a matter of seconds what may have been excellent physician-patient relations. On the other hand, if properly handled, the telephone can contribute much to the efficiency of the doctor and generate the good will so important to him.

This was engagingly stated by Dr. Hugh H. Hussey, whose plea was for "a soft answer—." In the course of his remarks, Dr. Hussey said:

> "It is up to us to learn to live with the telephone—to become tolerant of the enormous increase in demands that it makes upon us—to use it as an instrument for promotion of good will. We cannot expect patients to stop calling us, but we can teach the majority of them to place the majority of their calls at times most suitable to us. Also we can train ourselves and all who work with us to have good telephone manners.
>
> "Used in this way, the telephone does three things. It improves the quality of the medical care we give, it saves time, and it does promote good will.
>
> "There are a number of ways in which good use of the telephone improves the quality of medical care. A prime example is the 'follow-up' call, made for the purpose of extending the doctor's observation of the course of a patient's illness. In this connection, the doctor should be discriminating as to whose responsibility it is to make the 'follow-up' call. Not all patients can be relied upon to report as requested.
>
> "No one questions that the telephone is a time-saver. It would be even more effective if certain simple rules were generally observed. These are: 1. Make salutations informative without unnecessary embellishment. 2. Be realistic in appraisal of the possibility of delay. 3. Make delay as painless as possible for the waiting caller. 4. Try to group calls so that other activities won't be interrupted.
>
> "Promotion of good will by telephone is largely a matter of easy tone and pleasant manner, a willingness to make service or information easy to get, and an avoidance of indiscretions. In addition, the people in a doctor's office and home should be prepared for special handling of all kinds of emergency calls, whether or not the doctor is there.
>
> "Attention to these and other details, then, is a means for developing good telephone manners. For anyone who wonders whether or not he has such manners, here's a simple test.
>
> "When you talk with someone on the phone, do you always talk as though that person were seated with you in the room in which you are talking? If your answer to this question is Yes, you are using the telephone to improve your 'public relations.' If your answer is qualified or an honest No, use of the telephone is bad for your 'public relations.' But don't blame Alexander Graham Bell or the telephone; blame yourself. You don't have good telephone manners."

★

What the Grievance Committee Hears

One of the most enlightening and not infrequently onerous assignments which can come to a member of the Medical Society is service on the Grievance Committee. As those who have been or still are members will testify, their emotional reactions to complaints made by patients against their fellow physicians range from admiration for their colleagues to utter dismay.

It has become increasingly evident to the Committee that its activities must be more widely publicized among Society members if the number of complaints is to be reduced. Dr. Frank D. Costenbader, Chairman of the Grievance Committee, has long recognized this need, and the statement prepared by him, which was read, because of his illness, by a member of his Committee, Dr. A. Magruder MacDonald, is the first step in what Dr. Costenbader hopes will be a successful educational campaign. Here is a substantial portion of Dr. Costenbader's report.

> "Suppose someone wrote a letter to the Medical Society complaining about something that you had done or had not done. This is not a theoretical question, but one that has a practical application to every member of this Society, and, more broadly, to every member of the American Medical Association.
>
> "Since July 1, when the new Grievance Committee took office, 28 complaints have been reviewed by the Committee, and decisions have been handed down both to the plaintiff and to the doctor against whom they were directed. It is interesting to note into what category these complaints fall, to investigate some of the reasons for the filing of the complaints in the first place, and some of the dispositions of these complaints after the Committee had reviewed them carefully.

"Of the 28 complaints, 20 had to do with fees. The patient thought the doctor had charged him too much; the patient felt that the doctor had been inconsiderate in the duplication of services and charges; the patient didn't necessarily complain about the size of the charge, but didn't understand why it was made and had been unable to get satisfaction from the doctor's office with regard to this. All of these things had so intensely annoyed the patient that he then wrote a letter to the Medical Society, or, at times, directed one to the American Medical Association, and it was referred to the District Medical Society.

"Of the 8 cases in which the complaint was not directly about charges, 3 were cases in which the Committee felt that it had no jurisdiction. For example, the Committee will not consider any case before the Courts of Law. It feels that it has no responsibility or privilege to render a decision in such a case. Three of the various cases not involving fees had to do with matters of professional ethics. In such a case, one doctor will complain that another doctor had not conducted himself properly in his medical and public relations. Two cases involved a complete misunderstanding as to what the doctor had in mind, and why he did the tests which were done and instituted the treatment that he performed.

"From the above it will be apparent that money and misunderstanding are the basic complaints about doctors. When a complaint is made, the usual procedure is as follows. The Medical Society's office will accept such a complaint only in writing, and when the name and address of the doctor involved are specifically stated. The letter is then reviewed by the Chairman of the Grievance Committee and the Secretary of the Medical Society, and, in most cases, a letter is directed to the plaintiff acknowledging receipt of the letter and stating that he will be notified of the Committee's decision at some future time. At the same time, the doctor against whom the complaint is made is sent a letter asking him to come to the Medical Society, to review the material on hand, and to submit in writing the information that is available to him. Frequently it is necessary to contact several doctors in order to obtain related information, and, at times, with the patient's permission, hospital and other records are reviewed to obtain all relevant information. It should be stated here that much time and grief would be saved the Committee and the Medical Society at large if in his reply the doctor would state succinctly and briefly what he has done for the patient and what his charges have been, in detail.

"After the necessary information has been obtained, the material is then presented to the members of the Grievance Committee. This Committee consists of 10 members, 6 of whom have served previously, and among these 10 members general practice and the various medical specialties are well represented. After reviewing carefully the information available, the Committee decides whether the doctor has been at fault, whether the patient is at fault, or whether there has simply been a misunderstanding and neither is truly at fault. Following this, the Chairman of the Committee directs to the doctor and to the patient a summary of the Committee's thoughts. In this summary, the doctor may be told that his actions were completely justified and that the patient was not justified in the complaint, or, on the other hand, the Committee may tell the doctor that his fees should be reduced in toto or in certain respects, and that the acknowledgment of this decision to the Committee should be made by the doctor. At the same time the plaintiff is told that the Committee has reached a decision and that the doctor will get in touch with him soon and discuss with him the complaint and its settlement.

"Almost invariably the doctor realizes that the Committee has acted for his good as well as the patient's and accepts the decision that has been handed down. However, should the physician decide that he will not accept the Committee's decision, it is then necessary to cite that physician to the Executive Board for whatever disciplinary action it feels is wise. Fortunately, this rarely has to be done, but the Committee does not hesitate to follow such a course when it seems necessary."

"The chief reasons for the complaints filed with the Grievance Committee are due to a lack of understanding of the fee involved or to a failure on the part of the physician to thoroughly explain the medical condition with the tests and treatment necessary. The Committee recognizes that it is not feasible in many instances to enter into prolonged and involved explanation, but it does feel that a few words and an attitude of sympathetic understanding will avoid much ill will. A satisfied patient gets well faster.

"Three words of advice, then, from your Grievance Committee to you: 1. Discuss fees as early in the course of treatment as possible. Don't hesitate to initiate the discussion if necessary. 2. Discuss the medical condition as thoroughly as circumstances will allow. 3. Remember that one vocal and dissatisfied patient can do more harm to you and your colleagues than ten satisfied patients can undo."

★

"—Your Secretary—"

Dr. Darrell C. Crain, last speaker on the symposium, recognized that a humorous approach might be made to the topic assigned him, "Have You Looked at Your Secretary

Lately?" He surmised that the question posed in the title has "been answered rather promptly by many of you—and in many different ways."

"Some of you may facetiously have said, 'Sure, but don't tell my wife.' "

However, Dr. Crain had no intention of discussing his subject lightly, for he said: "It is hardly an exaggeration to state that the doctor's secretary is on many occasions and in many respects, his 'alter ego'—and what she does and how she acts profoundly affects his practice.

"I have frequently remarked that patients do not come to a doctor because of his secretary, but they will stop coming because of her. Such being the case, it is the responsibility of every physician to see to it that his secretary assists him in maintaining an office which is at once an efficient medical organization and a progressive public relations institution.

"Now—the attributes of a good secretary need not consume our time here; that she should be neat, courteous, efficient, quiet, punctual, mild-mannered, poised, self-assured but humble; long-memoried for some things and short-memoried for others; that she should have the knack of saying the right thing at the right time and being able to please all people at all times is, of course, the ideal.

"But we are not concerned with the traits themselves as much as we are with how we physicians may help the secretary attain and maintain them."

He offered the following suggestions to his fellow practitioners. The first, he stated, was suggested by a secretary.

" 'For goodness sake,' she said, 'tell the doctors not to treat us like pieces of office furniture.' It is indeed true, however strange, that a doctor may be quite conscious of each detail of the personal life of his patients and yet neglect even the common courtesies in regard to his own office personnel. But a secretary, too, will work better if the boss remembers to have a cheerful word for her at the beginning and end of the day, to notice her new hairdo, or new uniform, to compliment her on her handling of office affairs, and even to be interested in her personal life—her husband, or boyfriend—provided, of course, that he does not pry too closely into her private affairs.

"The second point I would like to make is that a secretary should be given a job to do—and then be left alone to do it. Too many employers—doctors as well as others—are so continually looking over the shoulders of their employees that the subordinates never feel free to make decisions or to consummate original projects.

"Closely allied to this is my next point: As a general rule—keep your family out of the office. Few things are more distracting to a secretary than to have the boss' wife flitting in and out, dropping by at odd hours, upsetting the routine, checking the records to see who has been in to call on her darling husband, and checking the cash drawer to see how much she can appropriate. I think there is even less excuse for the wife to help in the office—even once a month for the sending of bills and statements.

"I am glad you women are here tonight. I am not telling you that your place is in the home—Heaven forbid—but I am telling you most emphatically: Except on rare occasions your place is not in your husband's office!

"But I suppose I must hasten on to my next point. This has to do with the attitude of the physician toward the secretary when there is more than one girl in the office. This is a rather complex matter and no one generality will hold for all circumstances.

"Women who work together are extremely jealous. As a matter of fact, men are too, but we are not talking about them tonight. But the women can be jealous of just about everything—jealous of each other's duties, of each other's hours, of each other's salary, and particularly jealous, unless he is very careful, of the boss' attentions. Solomon, who should have known about such matters, said, 'It is better to dwell in the wilderness than with a contentious and angry woman.' And nothing makes for contentious and angry women in an office like one being favored above another.

"Closely related to this is another minor point—the manner of addressing the secretary. I abhor the growing tendency to call secretaries by their first name. The only possible exception to this would be if the doctor is quite old and the secretary quite young. And even here I feel it is in poor taste. . . .

"The final point I should like to make has to do with the financial remuneration granted secretaries for their work. This of course varies with the experience and abilities of the secretary, and even with the financial status of the employer.

"The salary of the secretary should certainly be adequate to take care of her needs—and to guarantee that she does not have to seek other work so as to be able to live comfortably. But I feel it should go beyond this. I believe that in every business there should be a plan whereby the employees share in the profits. . . ."

Dr. Crain concluded his remarks with the following: "Those of you who are students of the New Testament know that one of its greatest passages is the Thirteenth Chapter of the First Letter written by the Apostle Paul to the Church he founded in Corinth, Greece.

"In it, Paul exhorts the early Christians to have true love for all people and describes to them the virtues of that love. I should like to paraphrase that letter to apply to a secretary and read it to you in this manner:

> Though I speak with the tongues of men and of angels, but have not a good secretary, I am become as sounding brass or a tinkling cymbal.
>
> And though I have the gift of prophecy, and understand all mysteries, and all knowledge, and though I have all faith so that I could remove mountains and have not a good secretary, I am nothing.
>
> And though I have studied at the best universities, and have attended the noblest clinics, and though my diagnostic acumen is the finest and my therapeutic mastery the greatest—and have not a secretary who can collect the bills, it profiteth me nothing.
>
> A good secretary suffereth long and is kind, envieth not, vaunteth not herself, is not puffed up; doth not behave herself unseemly; seeketh not her own welfare, is not easily provoked, thinketh no evil; rejoiceth not in iniquity but rejoiceth in the truth; heareth all things, believeth all things, hopeth all things, endureth all things. A good secretary never faileth.
>
> And now abideth knowledge, a bedside manner, and a good secretary, these three—but the greatest of all is the secretary.

"Gentlemen—may you find such a secretary, and having found her, may you know how to keep her."

T.W.

WHAT YOU OWE OTHER DOCTORS*

ZIGMOND M. LEBENSOHN, M. D.

Associate Professor of Psychiatry, Georgetown University School of Medicine

The title of this dissertation deserves a note of explanation. To begin with it was not chosen by the writer, but rather by the Program Committee, to whom the writer is greatly indebted. To be sure, the title "What You Owe Other Doctors," may occasion mild wonderment at the best, and gross misinterpretation at the worst. In fact, some of my more facetious colleagues have twitted me for writing a learned paper on the technic of fee-splitting! I hasten to disclaim any such interpretation. Indeed, my contribution has nothing whatsoever to do with the economics of medicine but rather with the ethical concepts which bind all doctors together for the good of their patients. However, I have retained the revised title for more than capricious reasons. The habits and patterns of medical audiences are such that had I used the title "Medical Ethics" the audience-resistance would have been overwhelming and my colleagues, fearing just another sermon, would have stayed away in droves.

To return to our title, what is it that you owe other doctors? The primary debt we owe other doctors is two-fold: first, a debt of respect for them as fellow-workers; second, a debt of respect for the relationship which they have established with their patients. This implies an understanding of, and a respect for, the interpersonal relationships involved. Since psychiatry has often been defined as the study of interpersonal relationships, I suppose this is why a psychiatrist was invited to discuss this matter.

Since what you owe other doctors is chiefly ethical behavior, it may be well to examine carefully just what we mean by this word "ethics." People often have confused ideas of its meaning. Webster's Dictionary defines ethics as "the science of moral duty; more broadly, the science of the ideal human character and the ideal ends of human action." In other words, ethics can be defined as "moral principles."

It is in the carrying out of these "moral principles" that we can say that we are subscribing to a code of professional ethics. Although many pamphlets on this subject are available, this code is much more the unwritten law to which medical men willingly adhere and by which they practice. It is a code of conduct based on the highest moral principles. Its aim is simple and clear, namely, to help the doctor serve his patient with humanity and dignity.

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* Modified from a talk delivered as part of a Symposium "Look Again, Doctor!" before the Medical Society of the District of Columbia, November 4, 1953.

Contrary to popular belief, the code of professional ethics was designed to protect the patient, not the doctor. It is true, however, that the doctor who really understands the wisdom of ethical conduct and follows the code intelligently will rarely get into difficulty with either his colleagues or his patients.

To get down to cases, what are some of the specific things you owe other doctors?

1. *Respect for your colleagues' integrity and ability.* Altogether too often do doctors make disparaging comments about one of their colleagues, often in public. We may hear Dr. A say something like the following: "Oh, Dr. B? Why I wouldn't let him treat my dog!" Dr. A may well disagree with Dr. B's technics, his school of thought or his methods, but he does a great disservice to himself and to all of medicine by indiscriminately spreading such alarming tales. In making such a statement Dr. A may be attempting to indicate his own superiority to Dr. B. If so, it is a crude attempt and in the poorest possible taste. What Dr. A really succeeds in doing is to undermine the confidence of laymen in all doctors, a confidence which the science of medicine has labored for hundreds of years to build. This confidence is the most precious ingredient in the whole practice of medicine. Without it all other medicines fail. We must guard it zealously at any cost. And the cost is eternal vigilance of our personal conduct.

2. *The second obligation you owe other doctors is to respect their relationships with their patients.* Conversely stated, a doctor must not entice patients from his colleagues. This applies particularly when consultants are employed. We find that some doctors in general practice are now reluctant to refer patients for specialized attention to certain groups or certain medical buildings for the fear (often justified) that they will never see their patients again. If this is true, we should all take every possible step to correct it. How can this best be accomplished? I suggest the following:

a. A wider acceptance, particularly among specialists, of the priceless value of the patient's relationship with his family doctor. If this relationship is good and firm it is the consultant's solemn obligation to keep it good and firm. If it is weak, it is the consultant's obligation to strengthen it.

b. Placing greater emphasis on the physician's role as a teacher. All doctors are teachers; the very word "doctor" means teacher. Hence, a doctor is one who teaches his patients to get well and stay well. The consultant, however, has a double obligation. Not only must he teach the patient how to get well, but, equally important, he must teach the referring doctor something about his patient and the illness from which he suffers so that he may be better able to treat him in the future. Most specialties have been oversold but undertaught. It is the present-day responsibility of the specialist to teach his colleague with every case he shares.

3. *Careful understanding of the dissatisfied patient.* Special mention should be made of the problems involved in treating the patient who has been bitterly dissatisfied with his previous physician. It is so easy for Doctor No. 2 to sit in judgment and to nod his head in sympathetic agreement as the patient recites in gory detail all the mistakes made by Doctor No. 1. But is all this really helping the patient? Or is it merely contributing to the smugness of Doctor No. 2? And, more to the point, isn't it also contributing to our rising malpractice rate? Isn't it better to remain noncommittal and to concentrate on treating the patient as soon as the facts are known? An honest attempt to understand without bitterness is often rewarded by the establishment of an excellent doctor-patient relationship. Even more important, the patient's feelings toward medicine in general will have been greatly improved. This cannot be accomplished if Doctor No. 2 adopts a "holier than thou" attitude toward his predecessor.

There are many other obligations we owe our colleagues, but limitations of space permit me to mention only a few more.

4. We owe other doctors the best possible advice and assistance concerning their own personal and family medical problems.

5. We owe other doctors the practice of restricting our work to our own special field of competence.

6. We owe other doctors the courtesy of reporting, and reporting well, on the progress of a mutual patient. It is chiefly by such interchanges of information that the highest type of postgraduate medical education takes place.

7. We owe other doctors the obligation of keeping confidences, not only for the colleague's sake but for the patient's as well.

8. We owe all doctors the exercise of good taste

and common courtesy in all our dealings. Common courtesy, like common sense, is altogether too uncommon in these days of rush and hurry. Common courtesy is not a quality which can be successfully mimicked. If it is a pure surface gesture, it will be as transparent as a phony bedside manner. It must be deeply felt in order to have any true meaning to either the patient or to our medical colleagues.

The criticism may be made that my remarks have been too philosophical and too much concerned with ethics. My reply is that this is the greatest trouble with medicine today. Not enough attention is being paid to ethics in daily practice. Medicine is at a dangerous crossroads. Public confidence in the family doctor is waning. Frank cynicism is replacing the once familiar attitude of respect and adulation. Malpractice rates are soaring. Why all this? The complete answer is difficult to give. But one of the most important reasons is our failure to live fully to our code of professional ethics—a failure to give to other doctors what we owe them—call it respect, common courtesy, or ethical conduct. We must remember that ethical considerations enter into every phase of a doctor's life, not only during his office hours, but at all times.

We could probably discard all the minor rules in the guides and pamphlets and still practice the highest possible standard of ethics if we followed only one rule. It is an old rule, a simple rule, and a familiar one; but if followed faithfully it surpasses all the rest. It is: "Do unto others as ye would have others do unto you."

DOGS FOR MEDICAL RESEARCH

Editor's note: Following is the statement made by Dr. F. C. Fishback at a hearing before the Commissioners of the District of Columbia on December 4, 1953.

My name is Frederick Coleman Fishback. I appear before you as a representative of the Medical Society of the District of Columbia. I am a native Washingtonian, a graduate of Harvard Medical School and the Mayo Foundation, and Associate Professor of Surgery at Georgetown University. I am engaged in the practice of surgery here in Washington. The Medical Society of the District of Columbia wholeheartedly endorses your proposed order which declares "that it is the policy of the District of Columbia Government to make available for purposes of medical research and instruction at approved institutions, impounded animals which otherwise would be destroyed." Since 1896, when the first anti-vivisection bill was introduced in the Congress, our Society has gone on record opposing such legislation and its members have appeared as witnesses.

This proposed order is neither new nor untried. As far back as 1949, 25 medical schools in 20 different communities ranging widely from Virginia, West Virginia, South Carolina, Texas, Utah, Colorado to Kentucky, Arkansas, Tennessee and Michigan have had identical arrangements with local pounds. Since then a similar procedure for obtaining animals has been approved in Baltimore and Minnesota.

The present Pound Law was enacted in 1878, and among its provisions were, first, that impounded animals be held only 48 hours, and then that the Poundmaster, appointed by the Commissioners for an indefinite term, "may dispose of or destroy impounded animals as he deems advisable." At a hearing in 1949 we proposed that impounded animals be held 5 days to give owners a better opportunity to claim them. The District Code (1940, Title 22,-801, 802, and Title 11,-603) provides specific penalties for unnecessary cruelty to animals, and this cruelty does not have to be wanton, deliberate or willful. Furthermore, the Congress has granted the Washington Humane Society extraordinary powers under the Act of 1873, amended in 1885 and 1892 (Title 32,-205), which provides that the police shall arrest without warrant anyone guilty of cruelty to animals, at the request of a member of the Washington Humane Society after identification by his membership card. However, Title 22, Section 812 states that nothing contained in the sections pertaining to cruelty to animals "shall be construed to prohibit or interfere with any properly conducted scientific experiments or investigations, which experiments shall be performed only under the authority of the faculty of some regularly incorporated medical college, university, or scientific society." By order of previous Commissioners, the Poundmaster must pick up any dog not on a leash, whether it wears a dog tag or not. The Pound Law of 1878 was permissive and left the disposition of impounded animals entirely to the whim of the Poundmaster without any restriction or supervision by higher authority. In the past, the Poundmaster has asphyxiated upward of 70 per cent of all dogs impounded. All cats are asphyxiated.

In the light of the very adequate provisions regarding cruelty to animals in the District of Columbia Code, there is no instance where any charge of cruelty to a laboratory animal was sustained or proven. In the past, members of Congress have visited the animal laboratories of George Washington and Georgetown Medical Schools and found the care of the animals above reproach. Strict and rigidly enforced regulations governing the care and treatment of animals are posted in the laboratories of all schools and the National Institutes of Health.

In the 1920's I spent 2 years in the research laboratories of the Mayo Clinic and during that time I saw many dogs operated on but in no instance without benefit of complete general anesthesia. The care of animals before, during, and after operation is as good and considerate as that enjoyed by human beings in hospitals. Even that long ago dogs received intravenous feedings and endotracheal anesthesia, items now generally used on humans to enhance their comfort and safety while undergoing serious operations. It was through the perfection of these methods on dogs that such measures are now taken for granted as routine procedures on man. I am satisfied you will find no evidence of cruelty to animals in the school or governmental laboratories of Metropolitan Washington.

Washington has become a great medical center. It has 3 Class A medical schools and 2 graduate medical schools. Two new university hospitals have been completed, and more recently the magnificent new research hospital in Bethesda operated by the National Institutes of Health has opened its doors to patients. Both Walter Reed Army Hospital and the Naval Hospital in Bethesda, as well as the Bureau of Animal Industry and the Food and Drug Administration, contribute to the reputation of Washington as a leader in medical advances. All of these agencies have occasion to use animals for investigation and research.

Dogs have profited as much as man by their use as experimental animals. In 1921 the Bureau of Animal Industry, looking for a cure for hookworm in dogs, found that carbon tetrachloride was a safe and effective remedy. Its discoverer, the late Dr. Maurice Hall, after infesting himself, tried the drug on himself and was cured. In the last decade the same remedy was found to be effective in eradicating the liver fluke disease of sheep. Experimentation has led to the successful vaccination and protection against distemper, rabies and pellagra in dogs, as well as hog cholera and bovine tuberculosis.

The use of animals in medical research has contributed substantially to lengthening life and the arrest of disease. Were it not for the use of dogs as experimental animals there would be no insulin for diabetes or liver for pernicious anemia. The effectiveness and safe dosage of antibiotics were determined on animals before use on man. The potency of many drugs must, by law, be tested on animals. New anesthetic agents are always tried on animals before they can be used safely on humans. Thousands of our soldiers are indebted to animals, because it was by their use that the prevention and treatment of shock were perfected, as well as great improvements in surgery which proved lifesaving. The use of animals has given us valuable information concerning the after-effects and treatment of atomic radiation. Continuing medical progress and the betterment of national health depends on the humane use of these unowned, unwanted, and unhappy animals for beneficial research.

Washington, the Capital of our country, is the cynosure not only of our Nation but of the world. The adoption of this proposed order represents a real step forward in medical education and research, as well as national health. Although imponderable, good health is the true wealth of any nation. Health does not come from wishful thinking but from planning and research. Given sufficient time, dividends of better health will accrue to the far places of the world so that distant peoples may become capable of earning a decent living and cease to be a burden on the American taxpayer.

The Medical Society of the District of Columbia is proud to endorse this proposed order. It will redound to the credit of Washington and, in turn, to our country. If human lives are worth saving, if improvement of the Nation's health is a worthy project, if the relief from suffering is worthwhile, then this order will prove an indispensable weapon against the scourge of diseases that still beset man and beast.

REPORT OF DELEGATES TO THE AMA CLINICAL SESSION*

As usual, immediately preceding the meeting of the AMA House of Delegates, a day was devoted to a public relations conference. Of special interest to Washington physicians was the superb performance of the Chairman of our Committee on Public Information, Dr. Josephine Renshaw, who told about the public relations program in the Medical Society of the District of Columbia. Another outstanding item for all who attended the conference was a talk by Mr. Roger Fleming, Secretary-Treasurer of the American Farm Bureau Federation.

Mr. Fleming noted that many physicians have been embarrassed by the accusation that physician-sponsored policies are too often "negative" in their intent, that they lack a "positive" approach. He recommended that this accusation be answered by citing the Ten Commandments. He said that although seven of the Commandments begin, "Thou shalt not," this can hardly be labeled a "negative" document. Then he went on to say that Shenandoah Valley farmers regularly spray their apple trees with solutions that kill codling moths. "They do this," he said, "not because they're *against* worms but because they are *for* good apples."

The House of Delegates took important policy actions on social security, voluntary health insurance, medical ethics and unethical practices, medical education, hospital accreditation, military affairs and a wide variety of subjects affecting both physicians and the public.

Highlight of the opening House session on Tuesday was the announcement that Dr. Joseph I. Greenwell, of New Haven, Kentucky, had been selected by a special committee of the AMA Board of Trustees as the 1953 "General Practitioner of the Year." The annual medal and citation for community service by a family physician were presented to Dr. Greenwell by Dr. Edward J. McCormick of Toledo, Ohio, President of the American Medical Association, who also addressed the opening session.

The Tuesday program also included addresses by Dr. James R. Reuling, of Bayside, New York, Speaker of the House of Delegates, and Dr. Chester Keefer, of Boston, Special Assistant to Mrs. Oveta Culp Hobby, United States Secretary of Health, Education and Welfare. Annual reports were presented by Dr. George F. Lull, Secretary and General Manager of the AMA; Dr. Dwight H. Murray, of Napa, Calif., Chairman of the Board of Trustees, and by the standing and special committees of the House of Delegates.

Federal Legislation

Approving a recommendation by its Reference Committee on Legislation and Public Relations, the House passed a resolution reaffirming its opposition to the compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act and advocating passage of the Jenkins-Keogh bills now pending in Congress. These bills were described as providing for "the development of a voluntary pension program which is equitable, free from compulsion, and satisfies the retirement needs of physicians."

The reference committee report adopted by the House said: "The purpose of these bills is to eliminate the discrimination, and inequities which exist under present tax laws by extending the tax deferment privilege to the country's ten million self-employed and also to millions of employees who are not covered by pension plans. The purpose of the resolution is to reaffirm our support of the voluntary pension program provided in the Jenkins-Keogh bills and to reaffirm our strong opposition to the extension of compulsory coverage of physicians and other self-employed persons under Title II of the Social Security Act."

The same committee report urged continued action to obtain passage of the Bricker Amendment (S.J. Res. 1) and approved the principle of legislation which would reduce or remove the limitation on the deduction of medical and dental expenses for income tax purposes. It also opposed any further extension of the "Doctor Draft" Law beyond the present expiration date of June 30, 1955.

The report said that "your Committee feels strongly that there should be no further extension of the 'Doctor Draft' Law. We feel that the legislation is discriminatory and urge the Committee on Legislation and the Board of Trustees to actively oppose any further extension."

Voluntary Health Insurance

The House acted to accelerate the development of voluntary health insurance by passing a resolution requesting the Council on Medical Service to proceed immediately with a special study of the problems of catastrophic coverage and coverage for retired persons. The Council was asked to present its findings and recommendations to the House not later than the 1954 Clinical Meeting. The resolution pointed out:

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* The Seventh Clinical Session of the American Medical Association was held in St. Louis, Mo., December 1-4, 1953.

"There are two large groups of citizens for whom improved coverage could be offered under present prepaid medical care plans, namely: (a) those individuals who suffer catastrophic or long-continued and highly expensive illness and whose financial resources are not adequate to meet the cost thereof, and (b) those citizens who have retired and are living on small incomes and who are not eligible under presently existing public or private plans."

The resolution emphasized the medical profession's "responsibility to make every effort to promote such prepaid medical coverage for all citizens whose circumstances make them eligible."

Another resolution on voluntary health insurance, adjudged to be emergency business by the Reference Committee on Insurance and Medical Service and then passed by the House, stated that "the American Medical Association condemns all insurance contracts which classify any medical service as a hospital service." The resolution reaffirmed previous actions of the House defining pathology, radiology, anesthesiology and physiatry as medical services.

A second emergency resolution, which would have endorsed the principle of Federally-subsidized scholarships for prospective military personnel in order to encourage the building up of a career-basis medical corps for the armed forces, was referred by the House to the Board of Trustees for study and action.

A resolution introduced by the Iowa State Medical Society, calling for approval of a joint-billing procedure involving services rendered by two or more physicians, was referred to the Judicial Council, at the suggestion of the Reference Committee on Miscellaneous Business, with the recommendation "that the Judicial Council investigate the factors involved in the matter as presented and determine if there are new factors or new facets that would cause it to change the opinion" determined in 1952.

PUBLICITY PROBLEMS

The House approved a revision of one section of the Principles of Medical Ethics of the AMA which clarifies the relationship of physicians to all forms of public information media. The revision had been worked out by the Council on Constitution and By-laws.

In an effort to solve the publicity problems resulting from unethical practices by a small minority of doctors, the House referred to the Board of Trustees a resolution calling for appointment of a special committee with broad professional representation to study all aspects of the problems. The Board was asked to study and implement the intent of the resolution and to report its findings to the House at the June, 1954, meeting in San Francisco.

To clarify misunderstandings among physicians regarding the rules and regulations of the Joint Commission on Accreditation of Hospitals, especially as they concern the role of the Department of General Practice in a hospital, the House adopted the following resolution:

"That this House of Delegates of the American Medical Association request the Joint Commission on Accreditation of Hospitals to publish an article, or series of articles, in the *Journal of the American Medical Association* and other official publications circulating among the medical and hospital professions, to acquaint the medical-hospital profession with the regulations, by-laws and their interpretations, and

"That the Commission clarify the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement."

MEDICAL EDUCATION

In the field of medical education the House was "pleased to note" that a fourth grant of $500,000 had been made by the American Medical Association to the American Medical Education Foundation for financial aid to the Nation's medical schools. The Foundation reported that its 1953 income now totals $1,174,000 and that the number of contributors now is more than double the total in 1952.

Dr. Louis H. Bauer, of New York, immediate Past President of the AMA, was elected President of the Foundation just prior to the opening of the AMA Clinical Session. He succeeds the late Dr. Elmer L. Henderson, of Louisville, also an AMA Past President.

(*Continued on page 70*)

News and Personals

All members of the medical profession are invited to attend a **Sectional Meeting of the American College of Surgeons** to be held at the Hotel Charlotte in Charlotte, North Carolina, February 1–3, 1954. Although the meeting is designed for surgeons, it is open to all physicians in related fields, with no restriction on attendance from outside the area. This meeting is the first of six scheduled for various parts of the United States, Canada, and London, England, from February through May. Dr. H. Prather Saunders, Associate Director, the American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois, will be glad to furnish complete information about this meeting or other Sectional Meetings.

Fellows of the College, members of the Junior Candidate group, interns and residents are admitted without registration fees. Other doctors are charged a $5 fee, all of which goes toward paying a portion of the expense incurred by visiting speakers.

The 50th Annual Congress on Medical Education and Licensure will be held at the Palmer House, Chicago, February 7, 8, and 9. This Congress is conducted under the auspices of the AMA's Council on Medical Education and Hospitals and the Federation of State Medical Boards of the United States. More than 500 medical educators, officers and members of state licensing boards and others interested in postgraduate medical education are expected to attend.

The 14th Annual Congress on Industrial Health, sponsored by the AMA's Council on Industrial Health, the Kentucky State Medical Association, and a number of other national and regional groups interested in health and safety for the smaller industrial plant, will convene at the Brown Hotel, Louisville, Ky., February 24 and 25.

A pre-conference planning session will be held on February 23 for chairmen of state medical society industrial health committees and Council members to review progress during the past years and to determine future action.

The second **Postgraduate Course in Diabetes and Basic Metabolic Problems** to be conducted by the American Diabetes Association will be held at the Mayo Clinic and Mayo Foundation, Rochester, Minnesota, January 18, 19 and 20. Among the lecturers will be Dr. Charles H. Best, co-discoverer of insulin, and Dr. Joseph Hoet, Professor and Head of Medicine, University of Louvain, Louvain, Belgium.

The course is open to non-member physicians as well as to members of the ADA, but the number of registrants will be limited to 125. Fees are $40 to members and $75 to non-members. Details of the program, registration and hotel information may be obtained from J. Richard Connelly, Executive Director of ADA, 11 West 42nd Street, New York 36, N. Y.

The Council on Postgraduate Medical Education of the American College of Chest Physicians will sponsor a **Postgraduate Course on Diseases of the Chest** to be held in conjunction with the Tulane University of Louisiana and the Louisiana State University in New Orleans, February 15–19, with headquarters at the Roosevelt Hotel. Registration for the course should be made in advance with the College, 112 East Chestnut Street, Chicago 11, Illinois. The fee for the course is $75.

Dr. J. Winthrop Peabody, who is Chairman of the Council, will be moderator at the afternoon session on the opening day. His son, Dr. J. Winthrop Peabody, Jr., who is on the thoracic surgery service at Veterans Hospital, Oteen, N. C., will take part in a Symposium on the Pulmonary Mycoses. His subject will be "Nocardiosis."

The Alumni Association of the School of Medicine, College of Medical Evangelists, is sponsoring its **1954 Alumni Postgraduate Convention** in Los Angeles, Calif., February 23–25. Open to all physicians regardless of their school affiliation, the convention is geared primarily to the needs of general practitioners. Requests for information about the program should be addressed to the Managing

Director, Walter B. Crawford, 316 North Bailey Street, Los Angeles 33, Calif.

CALENDAR OF MEETINGS

NOVEMBER 15–DECEMBER 15, 1953

November 17	Grievance Committee
November 18	Subcommittee to Review Claims for Liability Insurance
	Woman's Auxiliary
	George Washington University Medical Society
November 19	Lay Society, Diabetes Association of D. C.
November 23	Executive Board
	Board of Censors
November 24	Committee on Industrial Medicine
	Public Speaking Course
November 25	District Board of Medical Examiners
	Committee to study proposed regulations governing maternal and newborn care in hospitals
December 1	Public Speaking Course
December 2	Committee for Health and Research
	Subcommittee to Review Claims for Liability Insurance
	Executive Board, Woman's Auxiliary
December 7	Committee on Public Information
December 8	Public Speaking Course
	Medical Officers' Reserve Units
	D. C. Society of Medical Technologists
December 9	Subcommittee on Venereal Disease
	Woman's Auxiliary
December 10	Committee on Public Policy
December 11	Committee on Social Affairs, Interstate Scientific Assembly
	Grievance Committee
	Washington Psychiatric Society
December 14	Subcommittee to Review Claims for Liability Insurance
	D. C. Chapter, American Federation for Clinical Research
December 15	Committee on Public Information
	Grievance Committee
	Public Speaking Course
	Society of Registered X-ray Technicians of Washington

The American Academy of General Practice announces its **Sixth Annual Scientific Assembly,** which will be held in Cleveland, Ohio, March 22–25, 1954. Among the headliners for the scientific program will be Sir Alexander Fleming, discoverer of penicillin; Dr. Howard Rusk, Medical Editor of the *New York Times*; and Dr. E. J. McCormick, President of the American Medical Association.

A full program is being planned for the wives of physicians, culminating with a President's Reception, the first the Academy has had, for the entire attendance.

Plans are well advanced for the **Third Interim Congress of the Pan American Association of Ophthalmology,** which is to be held in Sao Paulo, Brazil, June 17–21, 1954. Meeting concurrently in Sao Paulo will be the Eighth Brazilian Congress of Ophthalmology and the Nineteenth International Congress of Oto-Neuro-Ophthalmology. Simultaneous translations in English, Spanish and Portuguese will be provided for the sessions of the Interim Congress.

The registration fee of $10 will cover many of the events, including attendance at the other two congresses. Attendance is not restricted to members of the Association. Physicians who register for the Congress before the end of February will receive invitations to dinner parties in the homes of Brazilian physicians.

The United States representative on the Council of the Pan American Association is Dr. Daniel B. Kirby, 780 Park Avenue, New York, N. Y.

The Washington School of Psychiatry announces a series of eight lectures on **Psychiatric Jurisprudence** to be given by **Dr. Winfred Overholser,** Superintendent of St. Elizabeths Hospital. The course is designed for those people who are interested in a comparison of legal and psychiatric concepts and philosophy. The lectures will cover the following topics: (1) requisites of sound mental examination; (2) wills and deeds, torts, credibility of witnesses; (3) divorce and annulment, commitment laws; (4) criminal litigation; (5) establishment of responsibility; (6) opinion evidence; (7) doctors in court; (8) existing interrelations and possible methods of improvement.

The lectures will be held on Mondays, February 1–March 22, 1954, from 8 to 10 p.m. The fee for the course is $20.00. Registration may be made by mail or telephone to the Washington School of Psychiatry, 1711 Rhode Island Avenue, N.W., Washington 6, D. C., telephone Sterling 3-4373.

A course on Applied and Surgical Anatomy of the Head and Neck by **Dr. Othmar Solnitzky,** Professor of Anatomy and Director of the Department of Anatomy, Georgetown University Schools of Dentistry and Medicine, will be given at Georgetown University on Monday evenings, January 25 to March 15. The lectures will be 2½ hours long, from 7:30 to 10 p.m., once a week. The application fee is $5, the tuition fee, $50; enrollment is limited to 50. Application should be made to Georgetown University, Washington 7, D. C.

The District of Columbia Society for Crippled Children is sponsoring the following series of professional lectures, which will be held at the Society, 1767 Massachusetts Avenue, N.W., from 3:30 to 4:30 p.m., on the dates listed below.

January 26:	"Labor as an Etiological Factor in Brain Damage," John Parks, M.D., Professor of Obstetrics and Head of the Department, George Washington University School of Medicine
February 2:	"The RH Factor and Brain Damage," Oscar B. Hunter, Jr., M.D., Clinical Instructor of Medicine, Georgetown University School of Medicine
February 9:	"Heredity and Brain Damage," Richard Weber, Ph.D., Professor of Biology and Head of the Department, Georgetown College
February 16:	"Intrauterine and Neonatal Infections and Brain Damage," Mario Mollari, M.D., Professor of Bacteriology and Head of the Department, Georgetown University School of Medicine
February 23:	"Metabolic Disturbances and Brain Damage," Morris Michael, M.D., Instructor of Medicine, and Fellow in Pediatrics, Georgetown University School of Medicine

The lectures will continue through March and April; the subjects and speakers will be published in the February issue of the MEDICAL ANNALS.

The Section on Gastroenterology is sponsoring a Panel Discussion on Acute and Chronic Pancreatitis to be held in the Medical Society's auditorium, February 10, at 8:30 p.m. All members of the Medical Society are invited to attend. Dr. Robert J. Coffey, Professor of Surgery at Georgetown University School of Medicine, will be moderator for the panel. The etiology, diagnosis and management of the disease will be discussed, respectively, by Dr. Leonard W. Weyl, Washington; Dr. Moses Paulson, Baltimore; and Dr. R. F. (Mike) Bowers, of Memphis, Tenn. Open discussion from the floor will follow the formal presentation of the subject.

The Washington Orthopedic Club will present the **Custis Lee Hall Memorial Lecture** on Monday night, March 1, 1954, in the auditorium of the D. C. Medical Society, at 8:30 p.m. The lecturer will be Dr. Leo Mayer, of New York City, a distinguished orthopedic surgeon and an international authority on tendon surgery. His subject will be "The Evolution of Tendon Surgery."

The Washington Orthopedic Club has been sponsoring one lecture annually in commemoration of a deceased member. Dr. Hall practiced in Washington for many years and was well known both locally and internationally for his work in the field of orthopedic surgery.

The District of Columbia Division, American Cancer Society, reminds physicians that dressings are available, free of charge, to all cancer patients in Washington. Dressings, sterilized if needed, for home patients as well as those hospitalized may be obtained by contacting the D. C. Division, American Cancer Society, Inc., 1415 Eye Street, N.W., Washington 5, D. C., telephone Executive 3-3690. Office hours of the Society are from 9 a.m. to 5 p.m., Monday through Friday. Hospital patients should have the hospital personnel contact the Society, but home patients should get in touch with the Division directly.

The Seventh Annual Clinical Session of the American Medical Association, held in St. Louis, Missouri, December 1-4, 1953, attracted some 2,200 physicians, with a relatively small delegation from the District of Columbia. Dr. Hugh H. Hussey and Dr. Raymond T. Holden, the District Medical Society's official delegates to the AMA, and Theodore Wiprud, Secretary of the Society, attended the meetings of the House of Delegates in the Hotel Jefferson. Their report appears in this issue of the MEDICAL ANNALS.

Four members of the Medical Society took part in the scientific sessions, namely, Drs. Brian B. Blades, Frederic G. Burke, Andrew G. Prandoni and Oscar B. Hunter, Jr. Dr. Blades presented a paper on "Cardiac Arrest" in a meeting devoted to Cardiovascular Diseases, December 3. Dr. Burke gave the opening paper, December 2, in a program on Pediatrics; his paper was entitled, "The Diagnosis and Management of Bacterial Meningitis." Dr. Burke also took part in a "Stump the Experts" program presented before the general session, December 2, in which Dr. Lewis E. January, of Iowa City, Ia., was moderator. In addition to the Washington pediatrician, a surgeon and an obstetrician took part.

Two scientific exhibits bore Washington, D. C. labels: "The Use of Autonomic Blocking Agents in Cardiovascular Diseases," Captain Marvin Moser, MC, USAF, 1st Lieutenant Edmund H. Reppert, MC, USA, Dr. Andrew G. Prandoni, and Colonel Thomas W. Mattingly, MC, USA, Walter Reed Army Hospital; "Control of Cortisone Therapy in Rh Incompatibilities," Dr. Oscar B. Hunter, Jr., Doctors Hospital Research Foundaton and Georgetown University School of Medicine.

The Executive Board of the Medical Society of the District of Columbia met in regular session on November 23. The motion was made and carried that the Subcommittee on Veterans Affairs (of the Committee on Public Policy) be designated a special committee of the Society, to be known as the Committee on Veterans Affairs. The personnel of the Committee will remain as previously appointed: Dr. William P. Herbst, Chairman; Drs. Raymond T. Holden, William B. Walsh, Hyman D. Shapiro and Maurice A. Selinger.

Although the American Medical Association has a standing invitation from the Medical Society of the District of Columbia to hold the next unscheduled Clinical Session in Washington, the Board voted to extend a special invitation to the AMA to hold its 1957 Clinical Session in the District of Columbia.

It was contemplated by the Board that the 1953 Davidson Lecture be presented during the recent ANNUAL SCIENTIFIC ASSEMBLY. However, this was overlooked during the planning for the ASSEMBLY and plans for the Midwinter Seminar do not allow for inclusion of the Lecture. The Board voted that the Davidson Lecture, to be given by Dr. George E. Schreiner, be presented during the FIRST INTERSTATE SCIENTIFIC ASSEMBLY in November.

President Ramsey appointed the following members of the Society to serve as committee chairmen for the FIRST INTERSTATE SCIENTIFIC ASSEMBLY, to be held at the Shoreham Hotel, November 1, 2 and 3, 1954:

Program: Dr. Theodore Winship
Scientific and Public Health Exhibits: Dr. Alfred A. J. Den
Motion Pictures, Radio and TV: Dr. Joel B. Hoberman
Publicity: Dr. Josephine E. Renshaw
Social Events: Dr. Richard H. Todd
Finance: Dr. Robert U. Cooper

Dr. Ralph M. Caulk is General Chairman of the Committee on Arrangements and Dr. Den is Vice Chairman. Co-chairman for Virginia is Dr. J. W. Love of Alexandria. Theodore Wiprud will serve as Administrator for the ASSEMBLY and Lawrence A Zupan, Manager of Exhibits.

Belated mention must be made of the splendid **scientific exhibits** presented at the recent ANNUAL SCIENTIFIC ASSEMBLY. Three received special awards and three were cited for honorable mention. The exhibit on "Some Fundamentals of Wound Healing," presented by Drs. Philip A. Caulfield and Howard S. Madigan, Department of Surgery, Georgetown University School of Medicine, received First Award. Second Award went to Drs. Clemner M. Peck, Forrest V. Schumacher, Aubrey O. Hampton, and John V. Niiranen, of Groover, Christie and Merritt, for their exhibit, entitled "Resilient Plastic Replicas of Pathological Specimens and Their Clinical Applications." Dr. Benjamin Manchester, Department of Medicine, George Washington University School of Medicine, was given Third Award for his exhibit on "A Simple Blood Prothrombin Test for the Control of Dicumarol Therapy."

The following three exhibits were selected for Honorable Mention:

"Chemotherapy of Tuberculosis: Laboratory and Clinical Studies," Drs. Sol Katz, Monroe Romansky, Patrick Storey, George F. McCormick, and Edward C. Marshall, Jr., Pulmonary Disease Division, District of Columbia General Hospital, and Departments of Medicine, Georgetown and George Washington University Schools of Medicine

"Classification of Tumors of the Skin," Dr. Raymond A. Osbourn, Department of Dermatology, Georgetown University School of Medicine

"Fructose in Diabetic Emergencies," Drs. Henry Dolger, S. Kupfer, J. J. Bookman, and J. Carr, Mount Sinai Hospital, New York, N. Y. (by invitation).

The Section on Otolaryngology of the Medical Society of the District of Columbia held its regular bi-monthly meeting at the Army-Navy Club on November 18. Drs. Victor R. Alfaro and T. Frasier Williams reported on the proceedings of the fall meeting of the American Academy of Otolaryngology, which was held in Chicago, October 12–16. The next meeting of the Section is scheduled for January, 1954.

A Postgraduate Course in Pediatric Allergy is currently in progress at **Children's Hospital.** The course is stressing fundamental principles and the practical application of these principles in the routine management of the allergic child. Beginning January 5, the course will continue through the first 10 Tuesdays of 1954. The fee is $35.00. It is being conducted by members of the Allergy Clinic of Children's Hospital: Drs. Richard H. Todd, William A. Howard, Benjamin P. Lafsky, Clifford A. Webb, and the Director of the Psychiatry Department, Dr. Reginald S. Lourie.

The Scientific Council of the Washington Heart Association presented the following program, December 9, at Children's Hospital:

"Cardiac Arrhythmias in Infants and Children," Dr. Stanley L. Blumenthal

"Endocardial Fibroelastosis," Dr. John O. Nestor

"Tracheo-esophageal Vascular Rings," Drs. Bernard J. Walsh, Edgar W. Davis, and Marshall C. Sanford

"Surgical Closure of Auricular Septal Defects; Report of a Case," Drs. Bernard J. Walsh and Edgar W. Davis.

Recently elected officers of the **Medical Alumni of Georgetown University** are:

Dr. Raymond A. Osbourn, *President*; Dr. August Kram, *Vice President*; Dr. William D. Nolan, *Secretary-Treasurer*; Dr. Joseph J. Mundell, *member of the Board of Governors.*

More than a hundred physicians attended the **Pearl Harbor Day dinner meeting** of the **Physician-Veterans of World War II** at the Dupont Plaza, December 7. Dr. Frank S. Ashburn, President of the Chapter, presided.

A greeting from President Eisenhower was read to the guests assembled in which he commended the contributions made in the medical and health fields by military medicine during and following World War II. The letter is reproduced on page 42 of this issue of the MEDICAL ANNALS; copies of the letter were sent to all chapters of the National Medical Veterans Society.

During the program **Dr. William B. Walsh** was presented with an engraved sterling silver tray in recognition of the services he has given to the Physician-Veterans over the past five years. In addition to serving as President of the Washington Chapter, he has served as Chairman of the Legislative Committee of the national organization for two years and is now President-elect of the national group. Dr. Ernest A. Gould presented the tray to Dr. Walsh.

Patients at **Emergency Hospital** are now able to watch TV in their rooms and turn the dials from their bedsides without getting out of bed to do it. Twenty specially designed sets were put into operation, November 24, under the auspices of the Women's Board. Rental for the TV set is $2 a day. This charge will pay for the maintenance of the sets and provide some revenue for the Hospital Board's charity projects.

Posthumous award of the Army's Certificate of Achievement and the unveiling of a bronze plaque in honor of the late **Colonel Roy D. Halloran** were held, December 15, at the Walter Reed Army Medical Center. Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, presented the plaque, which was donated by the American Psychiatric Association, to Major General Leonard D. Heaton, Commanding General of the Center. Major General George E. Armstrong, Surgeon General of the Army, presented the certificate to a son and daughter of Colonel Halloran, Mr. Donald Halloran, of Washington, D. C., and Mrs. Franklin Navarro, of Dallas, Texas. Colonel Halloran is credited with establishing the groundwork for the Army's present-day psychiatric program in World War II.

The American Therapeutic Society at its meeting, May 31, 1953, established what will be known as the **Oscar B. Hunter Memorial Award** to commemorate "the many great contributions made by Dr. Hunter to the activities and continuing success of the (American Therapeutic) Society." This award will be presented by a special committee of the Council to the individual who, in the opinion of the committee, has made the most outstanding contribution to therapeutics during the preceding year. The special committee of the Council, to be known as the Committee on the Hunter Award, consists of eight physicians, including Dr. Oscar B. Hunter, Jr., an ex officio member. The award will be presented every year providing there is some outstanding work in therapeutics.

Dr. Frank D. Costenbader addressed the Tidewater Eye, Ear, Nose and Throat Society at Norfolk, Virginia, October 30, on "Factors in the Treatment of Strabismus." In Richmond, Virginia, November 3, he gave two talks before the Virginia Eye, Ear, Nose and Throat Society. They were entitled "Congenital Cataracts" and "Reading Difficulties from the Ophthalmologist's Viewpoint."

On January 19 Dr. Costenbader left for Los Angeles, where he will give seven talks before various scientific groups and then tour Southern California with Mrs. Costenbader.

Five Washington physicians participated in the midwinter meetings of the **American Psychoanalytic Association** in New York, December 4-6. Dr. Stanley L. Olinick read a paper entitled, "Questioning as a Psychoanalytic Technic." Drs. Marvin L. Adland, Donald L. Burnham, Frieda Fromm-Reichmann, and Harold F. Searles participated in a panel discussion on "Intuitive Processes of the Psychoanalyst Who Does Psychotherapy with Psychotics."

Several staff members of Georgetown University School of Medicine participated in a Cancer Symposium at Sacred Heart Hospital, Allentown, Pa., on December 3. Dr. Murray M. Copeland, Professor of Oncology, spoke on diagnosis and treatment of oral cancer; Dr. Robert J. Coffey, Professor of Surgery, cancer of the pancreas; Dr. Andrew A. Marchetti, Professor of Obstetrics and Gynecology, cancer of the cervix; Dr. Charles E. Rath, Assistant Professor of Medicine, leukemia; and Dr. Tiffany Lawyer, Assistant Professor of Neurology, tumors of the central nervous system.

Dr. John Minor, President of the Society of Medical Consultants to the Armed Forces, addressed the Society at its Eighth Annual Meeting at Walter Reed Army Medical Center, November 23. Dr. Minor, who is Chief of Medical Service at Emergency Hospital, discussed the role of consultants to the medical services of the Army, Navy and Air Force. Among the speakers during the day-long meeting were General Matthew B. Ridgway, U. S. Army Chief of Staff, and Major General George E. Armstrong, Surgeon General of the Army.

Dr. Wallace M. Yater, a Regent of the American College of Physicians, gave the principal address at the banquet during the Twentieth Anniversary Regional Meeting of the College at Chapel Hill, North Carolina, December 3.

Dr. Jacob J. Weinstein and Dr. Donald Stubbs were guest speakers at the Second Annual Scientific Session of the Delaware Academy of General Practice on December 12. Dr. Weinstein spoke on "Parenteral Carbohydrate Therapy in Medicine" and Dr. Stubbs discussed "The Management of Pain."

Dr. Murray M. Copeland, Professor of Oncology, Georgetown University School of Medicine, was the guest speaker before a meeting of the Philadelphia Orthopedic Club and the Orthopedic Section of the New York Academy of Medicine, November 6. He spoke on "Cartilaginous Tumors of Bone."

On November 17 he addressed the Seaboard Medical Association in Norfolk, Virginia, on "Premalignant Lesions of the Breast." On the same day he addressed the staff of the U. S. Naval Hospital in Portsmouth, Virginia, on "Diagnosis and Treatment of Oral Cancer."

At the meeting of the Southern Surgical Association, at the Homestead Hotel, Hot Springs, Virginia, December 8-10, Dr. Copeland discussed the paper on "Secondary Chondrosarcoma of Bone," presented by Dr. Bradley L. Coley.

Drs. Ralph M. Caulk, Alfred A. J. Den, and M. Noel Stow presented a refresher course during the meetings of the Radiological Society of North America in Chicago, December 13–18, at the Palmer House. The lecture series was concerned with "Tumors of the Eye, the Eyelids, and Orbit." More than 1,500 physicians attended the meetings of the Society in Chicago.

Dr. Robert P. Nenno has been appointed Assistant Professor of Psychiatry at the **Georgetown University School of Medicine.** A graduate of Notre Dame University and Loyola University School of Medicine, Dr. Nenno was Assistant Professor of Psychology at the College of St. Thomas, St. Paul, Minnesota, for two years. During two years of service in the Navy, he was on the staffs of Naval hospitals at Great Lakes, Ill., Charleston, S. C., and Bethesda, Md. He has lectured at Northwestern University and the South Carolina College of Medicine.

Dr. Zigmond M. Lebensohn was guest speaker at the annual meeting of the Neuropsychiatric Society of Virginia, which met in Roanoke, October 20. Dr. Lebensohn discussed "The Problem of Psychiatric Referral."

Dr. Andrew G. Prandoni, Chairman of the Cardiac Rehabilitation Committee of the Washington Heart Association, was the speaker at the luncheon meeting, December 3, of the Public Health Committee of the Washington Board of Trade. Dr. Prandoni spoke on "Rehabilitation of the Cardiac in Business and Industry." Dr. J. Ross Veal, Chairman of the Public Health Committee, presided at the luncheon, which was held in the Burlington Hotel.

Dr. Lawrence E. Putnam presented a paper on "Tetracycline, a New Antibiotic," before the Antibiotic Symposium, October 28, sponsored by the Department of Health, Education and Welfare in Washington, D. C. The paper was co-authored with Drs. F. D. Hendricks and H. Welch. Mention of this paper was inadvertently omitted from the news items regarding the Symposium carried in the December issue of the ANNALS.

On November 2, Dr. Putnam lectured to the intern staff at Emergency Hospital on "Fundamentals of Antibiotic Therapy."

Dr. J. Lawn Thompson has been elected to the Board of Directors of the National Bank of Washington.

The medical staff of **Columbia Hospital for Women** has established **memorials to the late Dr. Jesse T. Mann and Miss Catherine Beall,** both veteran members of the Hospital staff. Dr. Mann was Chief of the Department of Anesthesiology from 1940 until his death, February 14, 1953. Miss Beall had served on the nursing staff for 25 years and was supervisor of the delivery suite at the time of her death. The memorial for Miss Beall consists of a desk, chair, and mobile chart rack. The Mann Memorial is two stainless steel anesthetist's tables.

The Prince Georges County Medical Society has elected new officers. They are:

Dr. Julius Kauffman, Bladensburg, *President*; Dr. Benjamin S. Miller, Mount Rainier, *Vice President*; Dr. William B. Hagan, Mount Rainier, *Recording Secretary*; Dr. John S. Haught, Mount Rainier, *Corresponding Secretary*; and Dr. Albert Roth, Riverdale, *Treasurer*.

Dr. C. Herbert Marshall was reëlected President of the Federation of Civic Associations at a meeting in the District Building, November 20.

Dr. Julius Fogel was elected President of the Association of Reserve Officers of the United States Public Health Service at a meeting held in New York early in November. **Dr. James Q. Gant** was elected Secretary.

Dr. Joseph V. Kennedy has been elected President of the 1954 Merrick Boys Camp, which provides summer vacations for more than 500 underprivileged boys. The Camp is located on the Potomac River at Nanjemoy, Md.

Dr. W. Montague Cobb was elected President of the **Medico-Chirurgical Society of the District of Columbia,** December 17, succeeding Dr. Edward C. Mazique. Dr. Cobb is Professor of Anatomy at Howard University School of Medicine, Editor of the *Journal of the National Medical Association*, and an Active member of the District of Columbia Medical Society.

Dr. J. Mark Cox was elected Vice President of the Society; reëlected to office were Dr. Lillian G. Wheeler, Corresponding Secretary; Dr. Edward D. Crockett, Recording Secretary; and Dr. Claude P. Carmichael, Treasurer.

Dr. Benjamin Newhouse was honored by officers and friends of the Hebrew Home for the Aged, December 2, for his 39 years of service to the Home. Dr. Newhouse began his work with the Home in 1914; he is now chief of its medical staff. At the reception in his honor Dr. Newhouse was presented with a beautifully illuminated scroll.

Mr. Nate Haseltine, science reporter for *The Washington Post*, has been named the Nation's outstanding newspaper science writer for 1953 by the American Association for the Advancement of Science. Mr. Haseltine also won the AAAS-George Westinghouse Science Writing Award of $1,000 for his series of three articles on prisoner medical volunteers, which were published in the *Post*, September 6, 7 and 8. With other prize-winning writers, Mr. Haseltine received the citation and award at a special luncheon in Boston, December 29, during the annual meeting of the AAAS.

Mr. Haseltine joined the *Post* staff in 1946, after

CALENDAR OF SPEAKERS

The following members of the Medical Society of the District of Columbia have addressed lay groups during the past several weeks. The Society maintains a Speakers Bureau, sponsored by the Committee on Public Information, through which requests for speakers for lay groups, including radio programs, can be filled.

Date	*Speaker*	*Subject or Title*	*Organization*
October 27	Dr. Calvin T. Klopp	The Technologist's Role in Cancer Diagnosis	D. C. Society of Medical Technologists
November 3	Dr. V. L. Ellicott	Health Services Available to County School Children	Oak View Elementary School Parent-Teachers Association, Silver Spring, Md.
November 3	Dr. Charles A. Hufnagel	Some Aspects of Modern Treatment of Heart Disease	Society of Registered X-ray Technicians of Washington, D. C.
November 8	Dr. Lawrence E. Putnam	Ten Years of Antibiotics	Arlington-Fairfax (Va.) Jewish Center
November 11	Dr. Louis Goldstein	The Anatomy, the Physiology and the Hygiene of the Female	Sophomores and Juniors, the University of Maryland, College Park
November 16	Dr. Edward M. Pickford	Alcoholism and the Work of the Alcoholic Rehabilitation Program Clinic	Connecticut Avenue Citizens' Association
November 17	Dr. Anthony Zappala	Drug Addiction in Teen-agers	Sociology Club at Trinity College
November 18	Dr. Louis Goldstein	The Anatomy, the Physiology and the Hygiene of the Female	Seniors, the University of Maryland, College Park
November 24	Dr. Leonard A. Scheele	New Vistas in Cancer Research	University of Michigan Club
December 3	Dr. Marshall M. Parks	Panel Participant, Let's See. . . Half of All Blindness Can Be Prevented	Prevention of Blindness Society of Metropolitan Washington
December 8	Dr. James J. Feffer	Present Status of Tuberculosis	Civitan Club
December 8	Dr. Edward M. Pickford	The Problem of Alcoholism in a Tuberculosis Hospital	Nurses at Glenn Dale Sanatorium

having served with an Army artillery unit in the European Theater of Operations during World War II. He has been science reporter since 1949. He is well known to Washington physicians for his able coverage of medical meetings in the Washington Metropolitan Area. The Editorial Board of the MEDICAL ANNALS joins his many physician-friends in congratulations upon these well deserved honors.

Dr. Ferdinand Welebir discontinued his Washington practice on October 1 and has moved to Riverside, California, where he is associated with another urologist in offices at 3768 Twelfth Street.

Dr. Harle B. Grover, orthopedic surgeon, formerly of Washington, is now a member of the Collom and Carney Clinic at Texarkana, Arkansas-Texas.

Mr. Willard C. Smith, Administrator of Hospital Service Agency, died, November 27, 1953, in Doctors Hospital. He was known to many doctors through his devotion to social welfare and health activities in the Washington area. He was a member of the citizens' committee that organized the first Community Chest over 20 years ago and had served as President of the Council of Social Agencies, predecessor of UCS.

A native of Winchester, Illinois, Mr. Smith was educated at the Illinois State Teachers College and the University of Chicago. He received his Master's degree in sociology from George Washington University. He joined the Hospital Service Agency in 1935 as a member of the Board of Directors; in 1940 he was appointed Administrator of the Agency.

He is survived by his wife, Mrs. Maybelle Rucker Smith, who resides at their home, 3020 Tilden Street, N.W.

Following the death of Mr. Smith, **Mr. Richard M. Gaffney,** for many years Comptroller of HSA, was appointed Acting Administrator of the Agency.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, November 23, 1953, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society.

Active Members

Dan G. Albert, 1605 22nd Street, N.W.
Roger Baker, Georgetown University Hospital
Mary Louise Barker, 3900 16th Street, N.W.
Maxwell Boverman, 1728 Massachusetts Avenue, N.W.
Arthur S. Bresler, 5417 Chillum Place, N.E.
James E. Chapman, 2026 R Street, N.W.
William Chin, 1710 Que Street, N.W.
Paul B. Cornely, 3103 13th Street, N.E.
George Campbell Darr, 3000 Connecticut Avenue, N.W.
Arthur T. Davidson, 400 13th Street, N.E.
Robert J. Faulconer, Walter Reed Army Hospital
Marvin M. Gibson, 1835 Eye Street, N.W.
Leroy E. Hoeck, 2502 Colebrooke Drive, Hillcrest Heights
James Louis Keating, 238 South Virginia Avenue, Falls Church, Va.
Charles E. Keegan, Jr., 1617 35th Street, N.W.
Christine Kehne, 4201 Massachusetts Avenue, N.W.
Tiffany Lawyer, Jr., 3800 Reservoir Road, N.W.
E. Anne D. Mattern, 10243 Parkwood Drive, Kensington, Md.
Samuel B. McCottry, Jr., 2812 12th Street, N.E.
Arnold Namrow, 611 Beacon Road, Silver Spring, Md.
John P. Nasou, 725 Dartmouth Avenue, Silver Spring, Md.
Thomas Joseph O'Connor, 3681 Alabama Avenue, S.E.
Tom D. Raaen, Mt. Alto Veterans Administration Hospital
Edward L. Rea, 1400 Aspen Street, N.W.
Norman H. Rubenstein, 407 37th Place, S.E.
William Shakin, 209 Valley Avenue, S.E.
Maurice Arthur Sislen, 5734 First Street, N.W.
James A. Sowers, 1746 K Street, N.W.
Laszlo Tauber, 1503 Good Hope Road, S.E.
J. Richard Thistlethwaite, 427 Lebaum Street, S.E.
Russell M. Tilley, Jr., 4325 49th Street, N.W.
John B. Umhau, Jr., 1327 Jefferson Street, N.W.
Daniel Leigh Weiss, Department of Laboratories, D. C. General Hospital
Louise O. Wensel, 2218 Wisconsin Avenue, N.W.
Stanley I. Wolf, 3511 Davenport Street, N.W.

Associate Members

Stanhope Bayne-Jones, 1306 27th Street, N.W.
Hugh S. Geiger, Jr., 2716 Kirkwood Place, West Hyattsville, Md.
Max M. Herzberg, 300 Aspen Street, N.W.
Marion Elizabeth Maclean, 647 Maryland Avenue, N.E.
Paul A. Morin, D.M.D., 1726 Eye Street, N.W.
Charles L. Smith, D.D.S., 1149 16th Street, N.W.
H. Robert Unger, Mayflower Hotel
W. Leonard Weyl, 2118 37th Street, N.W.
M. Henry Williams, Jr., Army Medical Service Graduate School, Walter Reed Army Medical Center

Resident-Intern Members

Jean D. Lockhart, 4600 Yuma Street, N.W.
Julius S. Piver, 1423 Meridian Place, N.W.

The following applicants for membership will be voted on at the meeting of the Executive Board, February 23, 1954:

For Active Membership

Salomon N. Albert, American University of Beirut (Syria)—1940
Margaret Ann Clark, Syracuse Medical College—1949
Abraham I. Gimble, George Washington University—1952
Margaret Elizabeth Grigsby, University of Michigan—1948
Donald Keller, Howard University—1941
William H. Kessenich, Georgetown University—1946
William G. Lofton, Jr., Howard University—1947
James P. Mann, George Washington University—1947
Richard J. Meyer, Georgetown University—1946
Seamus P. Nunan, Georgetown University—1947
William G. Pogue, Howard University—1945

For Associate Membership

Paul I. Bauman, Georgetown University—1939
Homer L. Reighard, Temple University—1948
William F. Schnitzker, University of Maryland—1947

For Resident-Intern Membership

James M. Clements, Georgetown University—1952
Nizar N. Oweida, American University of Beirut (Syria)—1950

Recent changes in membership status:

Reinstated to Active

Frederick W. Coe

Active to Associate

Herbert H. Diamond
Mary Stuart Fisher
Jason Geiger
Ernest S. Hendry
Wallace H. McCune
Francis Jerome Murphy
William J. Schewe

Active to Affiliate

M. Hayne Kendrick

Resident-Intern to Associate

Anatol J. Linder

Resigned
Active

John F. Crosby, Jr.
Robert P. Hill
Harold W. Kagan

Twelve New Life Members

Chapter II, Article IV, of the Constitution of the Society, reads as follows:

> Life members shall be active members who have been active members for a total of forty years. They shall have all the privileges of active membership and shall be exempt from paying dues and assessments.

Our honor roll now numbers 78. The congratulations of the Society are extended to:

Seniority Number		*Date of Membership*
598	James Madison Moser	February 25, 1913
599	Daniel LeRay Borden	February 25, 1913
602	John Burr Piggott	March 18, 1913
603	Joseph A. Jeffries, Jr.	March 18, 1913
612	Richard Lee Spire	December 3, 1913
613	Joseph J. McCarthy	January 3, 1914
615	Caryl Burbank	January 8, 1914
621	William S. Hardesty	January 16, 1914
626	Edith Seville Coale	February 17, 1914
636	Arthur B. Little	June 4, 1914
637	Benjamin Newhouse	June 10, 1914
641	Davenport White	December 2, 1914

who have for forty years been on the roster, meeting all dues and assessments and lending their support to the Society by frequent attendance. Their status is now elevated to Life membership.

BOOK REVIEW

Sexual Behavior in the Human Female. ALFRED C. KINSEY, WARDELL B. POMEROY, CLYDE E. MARTIN AND PAUL H. GEBHARD, Research Associates, and others on the Staff of the Institute for Sex Research, Indiana University. Price, $8.00. Pp. 842, with 151 charts, 179 tables, and 4 illustrations. Philadelphia: Saunders, 1953.

The general hullabaloo which accompanied the launching of Dr. Kinsey's much-awaited volume on the human female has been even greater than that which followed his study on the human male in 1948. I am sure that this has surprised no one, especially not Dr. Kinsey, who, wittingly or unwittingly, has developed a true genius for these things.

Nonetheless, the publication of this volume has stirred violent and intemperate controversy in many fields of thought. This fact makes it all the more important for the medical reviewer to stick to his last. All temptations to moralize, philosophize and speculate will be resisted. Rather, an attempt will be made to evaluate this contribution in terms of its general medical usefulness. It is ironic indeed that this work, written by serious scientists, dealing with a subject of medical (although not exclusively medical) nature, and printed by a well-known medical publishing house, should receive its medical assessment so long after the clamor has subsided—ironic, perhaps, but also very much in keeping with the medical tradition of not making a diagnosis in haste. It is safe to assume that the subject will keep. Both medicine and sex are here to stay.

Dr. Kinsey and his co-workers have based their findings on data derived from painstaking interviews with 16,392 persons, 8,603 males and 7,789 females. Of these, only 5,940 cases of white, non-prison females living within the continental limits of the United States were used for the statistical analyses in the present volume. This study, like its companion study on the male, was conducted by the staff of the Institute for Sex Research of Indiana University and supported by the National Research Council, with grants from the Medical Division of the Rockefeller Foundation.

The entire project, which has been in progress since 1938, was inspired by the numerous questions on sex behavior brought to the senior author by his students in biology. Since Dr. Kinsey was unable to find satisfactory factual and scientific answers to these many questions in the existing literature, he embarked on the now famous studies which have made his name a household word. He has approached his present work, as he did the preceding volume, as a serious scientist, a biologist, and, more particularly, a taxonomist. This fact must be remembered and clearly understood before any fair evaluation can be made. "The taxonomist," Dr. Kinsey stated in his first volume, "is primarily concerned with the measurement of variation in series of individuals which stand as representatives of the species in which he is interested." But this time Dr. Kinsey has not stopped with the mere collection and tabulation of data. He has made numerous inferences and suggestions as to the areas in which his data might apply to the further understanding of diverse human problems. Although such applications were not the original objectives of the study, herein lie the potential strength and potential weakness of his book, which only further experience will resolve.

A simple example of the application of his data lies in the medico-legal field. Some foreign jurisdictions (notably Denmark and Switzerland) have provided for castration of male sex criminals. Dr. Kinsey's data, demonstrating preservation of sex function in adult male castrates, clearly indicate that castration laws do not provide any sure-fire protection from socially dangerous types of sex offenders. And he does not hesitate to spell out this type of application throughout the volume.

Dr. Kinsey in both his studies has been accused of being merely an "orgasm counter." Sensitivity to this criticism has doubtlessly led the authors to make the following statement in the section on "Significance of Orgasm": "It cannot be emphasized too often that orgasm cannot be taken as the sole criterion for determining the degree of satisfaction which a female may derive from sexual activity. Considerable pleasure may be found in sexual arousal which does not proceed to the point of orgasm, and in the social aspects of a sexual relationship." Despite such a statement, numerous readers will be troubled by the conspicuous absence of all reference to the profound emotional components which ordinarily accompany most sexual relationships. He has deliberately refrained from entering this complex field in order to restrict his work to the collection and tabulation of reportable data. This is understandable enough, but this reviewer feels strongly that his findings must be carefully integrated with the data of psychiatry and sociology (to mention only two fields) before any general application of his findings becomes valid.

The present volume is divided into three parts. The first deals with History and Method, which includes a carefully worded section on "The Scientific Objective," an eloquent statement on "The Right to Investigate," and "The Individual's Right to Know." Here, too, is a thoughtful discussion of the enormously difficult problems of sampling in a sex study. Since the data were derived only from females who were willing to coöperate, the sample may be justifiably criticized as being unrepresentative in this regard. It may even be argued that only those uninhibited females with rather extensive sexual experience would coöperate in such a study. This is belied by the statistically valid sample of women in the series who had a minimum of sex experiences. (Two per cent of the females had never been aroused erotically in their lives!) It is true that the sample is heavily loaded in the direction of the educated versus the non-educated female (75 per cent of the sample had some college background), and this is freely admitted by the authors. They further admit that the sample of females is inadequate in representing the lower educational levels, rural groups, devoutly religious females, and females born before 1900. It is hoped that these inadequacies will be rectified as the study continues.

In Part II, Types of Sexual Activity Among Females, the authors discuss preadolescent sexual development, masturbation, nocturnal sex dreams, premarital coitus, marital coitus, extramarital coitus, homosexual responses and contacts, and animal contacts. Although this section is encyclopedic in its thoroughness, the many varieties of sexual activity will come as no great surprise to the experienced clinician. What may surprise most readers are some of his figures and some of his inferences developed especially in the last section, entitled "Total Sexual Outlet." It is stated, for example, that there was a very high correlation between the frequency of orgasm in marital coitus with the presence or absence of premarital experience in orgasm regardless of method. Among women who had no previous experience, 44 per cent failed to achieve orgasm; but among those who had some premarital experience only 19 per cent failed to reach orgasm within the first year of marriage. Although the authors cite the importance of selective factors (i.e., the girls who respond by orgasm to premarital experiences are probably those who are basically the more responsive ones), nonetheless the point is clearly made that experiences in premarital orgasm (especially those achieved in premarital coitus) have a positive causal relationship to the capacity to experience orgasm in marital coitus. These conclusions are not entirely convincing, chiefly because the vital and complex role of the emotions is neglected in favor of constitution and sex experience.

From the purely medical viewpoint the most valuable portion of the book is to be found in Part III, Comparisons of Female and Male. Here the anatomy and physiology of sexual response and orgasm are meticulously presented and compared. The psychologic, neural and hormonal factors in sexual response are also discussed. Some of the findings are quite striking. For example, Dr. Kinsey finds males and females essentially alike in the basic anatomy and physiology having to do with sexual responsiveness. Discussing orgasm in the female, he casts considerable doubt as to the validity for distinguishing between "clitoral" and "vaginal" orgasm, or whether a so-called "vaginal response" can be said to exist in view of the insensitivity of the vagina.

But the phenomenon of orgasm itself, he concludes, is essentially the same in female and male. The popularly held view that "women are slower" is explained by Dr. Kinsey on the basis that females seem to be less often stimulated by psychologic factors, and may therefore not respond so quickly in socio-sexual relationships. Contrary to general opinion, he finds that females are capable of reaching orgasm as quickly as males if there is sufficiently continuous tactile stimulation. This statement fails utterly to explain the situation frequently encountered in clinical practice wherein a woman on the verge of reaching orgasm is suddenly blocked by a profound emotional or "psychologic" stimulus, e.g., her husband's inadvertent mention of another woman's name. On such an occasion the husband may provide "continuous tactile stimulation" from now to eternity without the slightest chance of producing orgasm.

The studies reveal also that women in general are not sexually aroused by viewing erotic pictures, displays of nudity, observation of sexual behavior, or other psychologic stimuli which are ordinarily exciting to the average male. Although the authors make allowance for the tremendous individual variation in this regard (they suggest that one third of the females of the population may be as frequently affected by psychologic stimuli as the average of the males), nonetheless they tend to view this variation in response to the psychologic stimuli as a fundamental biological difference. In the reviewer's opinion, insufficient weight is given to the complex emotional and cultural factors involved.

The inference is made throughout the volume that there is something askew with the sex life of American women to account for many of our ills, as, for example, the substantial number of women who never reach orgasm in marriage. To the clinician who studies and treats such women, the problem lies not so much with the sex life as it does with the patient's love life. Therein lies an enormously important distinction. Unthinking people tend to equate love and sex. On the contrary, love may exist without sex and sex may exist without love. The problems that arise purely from a lack of sex knowledge are usually simple to manage, and for such problems this book will prove to be an indispensable source. However, those that arise from deep-seated emotional problems involving love and hate are by far the more important, the more prevalent, and the more difficult to resolve. These important emotional factors have hardly been mentioned, nor was it the authors' purpose to do so.

What the authors have set out to do they have accomplished; and they have done it in a scholarly, readable, and highly competent fashion. Scientific investigation in this sensitive field has encountered enormous obstacles which have been surmounted only by great courage and rigid adherence to scientific principle. For this the authors deserve the greatest credit. Whatever its defects in method, sample, or conclusions, this study is unique in scope. No study in modern times has analyzed as large a number of subjects in so thorough a fashion. Physicians will find this book of inestimable value in providing background data for the numerous problems involving sexual behavior which find their way into the doctor's office.

Zigmond M. Lebensohn, M.D.

ALEXANDER YELVERTON PEYTON GARNETT, M.D.

(1881–1953)

Dr. A. Y. P. Garnett, pioneer among Washington obstetricians, died, November 4, 1953, at his home, 1824 Massachusetts Avenue, N.W. A native of

Washington, he began his practice in the District of Columbia in 1908 and retired in 1945.

Dr. Garnett was born in Washington, D. C., June 9, 1881, the son of Henry Wise Garnett, a lawyer, and Marion Monson Garnett, and the grandson of Dr. A. Y. P. Garnett, at one time Surgeon General of the Confederate Army, for whom he was named. Dr. Garnett was educated at Emerson Institute and received his medical degree from the University of Virginia in 1906. He interned at Hudson Street Hospital in New York. In 1908 he was house surgeon at the New York Lying-in Hospital; on October 1 of the same year he opened his office for practice in the District of Columbia.

In 1913 Dr. Garnett reorganized the Obstetrical Department at Garfield Memorial Hospital, placing it in a separate building. Later Dr. and Mrs. Garnett furnished and decorated all the rooms on one floor of the department. Dr. Garnett continued as Chief of Obstetrics at Garfield until he retired in 1945.

From 1916 to 1930 he was Associate Professor of Obstetrics at Georgetown University School of Medicine. During World War I he served as Captain in the Medical Corps of the U. S. Army.

Dr. Garnett was always willing to share his knowledge with younger doctors, interns and nurses. According to one of his colleagues, "he never refused to help anybody." He wrote extensively on the subject of obstetrics.

In his student days Dr. Garnett had played football at the University of Virginia. An avid sportsman, he enjoyed hunting and fishing with his friends. At the age of 65 he won a professional-amateur golf tournament at the Chevy Chase Club. He was a student of the Civil War and read constantly on the subject.

Dr. Garnett was a Life member of the District Medical Society, his membership dating from 1909. He was a diplomate of the American Board of Obstetrics and Gynecology, and a member of the American Medical Association, the Southern Medical Association, the American Association of Obstetricians, Gynecologists and Obstetrical Surgeons, the Virginia Medical Society, and the Washington Gynecological Society. He was formerly a member of the Chevy Chase, University, and Metropolitan Clubs.

Survivors are his wife, Mrs. Mildred Poor Garnett; two sons, A. Y. P. Garnett, Jr., Greenwich, Conn., and Dr. James H. P. Garnett, Hartford, Conn.; and two sisters, Mrs. Harry S. Venn and Miss Ellen Garnett, both of Washington, D. C.

RUSH WEST CONKLIN, M.D.

(1877–1953)

Dr. Rush West Conklin, a Life member of the Medical Society of the District of Columbia, died, November 2, 1953, at Sibley Memorial Hospital. He had practiced medicine in Washington for 44 years.

Dr. Conklin was born in Milton, Pennsylvania, March 15, 1877, the son of John and Alice Edkin Conklin. His birth interrupted a journey west to Topeka, Kansas, which his parents and others were making in covered wagons; because of these circumstances he secured his first and middle names.

Dr. Conklin came to Washington in 1899 and worked as a binder in the Government Printing Office for 10 years. During those years he studied medicine at George Washington University and received his degree in 1909. He opened his practice in Washington in 1910. In recent years his office and home have been located at 3100 20th Street, N. E.

Dr. Conklin was elected to membership in the District Medical Society in 1902 and became a Life member in 1953. He was a member of the American Medical Association, the American Academy of General Practice, and the George Washington University Medical Society. He was a trustee of the First Congregational Church.

Survivors are his wife, Mrs. Beryl Brown Conklin; two sons, Roscoe L. Conklin, Hyattsville, Md., and Paul E. Conklin, Alexandria, Va.; three daughters, Mrs. James Silver, Atlanta, Ga.; Mrs. John E. Kester and Mrs. Arthur G. Hughes, Jr., of Washington. A brother, Archie Conklin, of Tampa, Fla., also survives him.

Rehabilitation in Neurologic Disorders—Bailey and Korengold

(Continued from page 6)

and which could not be used if available, due to the lack of qualified personnel in this field. The fact that rehabilitation of neurologic patients has advanced as far as it has in the face of these odds demonstrates the value and need for such programs. It is the only hope for many chronic neurologic patients to live a livable and useful life in the present state of our knowledge.

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Report of Delegates to AMA

(Continued from page 56)

At the opening session of the House, Dr. McCormick in his presidential address made a strong appeal to the Nation's physicians for "action that will further the full confidence of the public in our profession."

"Good public opinion cannot be bought," he declared. "It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the AMA and its constituent societies spend for public education and public relations is wasted unless individual physicians take wholehearted interest in assuring the success of these ventures."

Dr. Reuling, emphasizing that much serious work remains to be done, warned that "times are just as troubled as when we had blanket bills before Congress which would have socialized the practice of medicine."

Dr. Keefer told the House that "the voluntary way has been the most successful in the past and there is no reason to believe it will not continue to be in the future." He urged maximum effort, cooperation and leadership on the community level.

Just prior to the Clinical Meeting the Joseph Goldberger award for outstanding contributions in the field of clinical nutrition was presented to Dr. James Somerville McLester of Birmingham, Alabama, a practicing physician for more than 50 years. The award was presented by the AMA through its Council on Foods and Nutrition.

Final registration at the St. Louis Clinical Session totalled approximately 7,500, including about 2,700 physicians.

Respectfully submitted,
Hugh H. Hussey, M.D., *Delegate*
Raymond T. Holden, M.D., *Delegate*
Theodore Wiprud, *Secretary*

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MEDIASTINAL TUMORS*

OTTO C. BRANTIGAN, M.D., F.A.C.S.

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ANATOMICAL CONSIDERATIONS

THE PROBLEM of mediastinal tumors is broad and ill-defined. From the clinical aspect it is difficult to distinguish true neoplasms from mediastinal masses. Without thoracic exploration it is often impossible to distinguish mediastinal masses or neoplasms from masses or neoplasms in the lung or chest wall. Anatomically the mediastinum is fairly well defined; however, there is some ambiguity. The vertebral gutter, where many neurofibromas occur, usually is considered from a clinical point of view to be a part of the mediastinum, but in the strict anatomic sense it lies outside the mediastinum. The thyroid that normally is situated in the neck is sometimes found in the mediastinum but often is not considered with mediastinal neoplasms. As a result of neoplasms or masses the mediastinum can be altered in size and position. The histologic nature of mediastinal neoplasms is frequently not well understood, and the final diagnosis rendered by the pathologist does not indicate the amount of study, careful consideration, and possible misgivings included in the final pathologic diagnosis.

The standard textbooks of anatomy fairly well agree that the mediastinum is a space or septum limited anteriorly by the sternum, posteriorly by the bodies of the 12 dorsal vertebrae, superiorly by the plane of the superior thoracic inlet, inferiorly by the diaphragm, and laterally by the mediastinal pleura. The mediastinum is arbitrarily divided into a superior and inferior division by an imaginary plane passing through the junction of the manubrium and body of the sternum anteriorly and the lower border of the body of the fourth dorsal vertebra posteriorly. The inferior mediastinum is further subdivided into a middle mediastinum considered to be coterminous with the fibrous pericardium; the anterior mediastinum lies in front and the posterior mediastinum behind the fibrous pericardium or the middle mediastinum. Anson[1]

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* Delivered at the 24th ANNUAL SCIENTIFIC ASSEMBLY of The Medical Society of the District of Columbia, October 7, 1953.

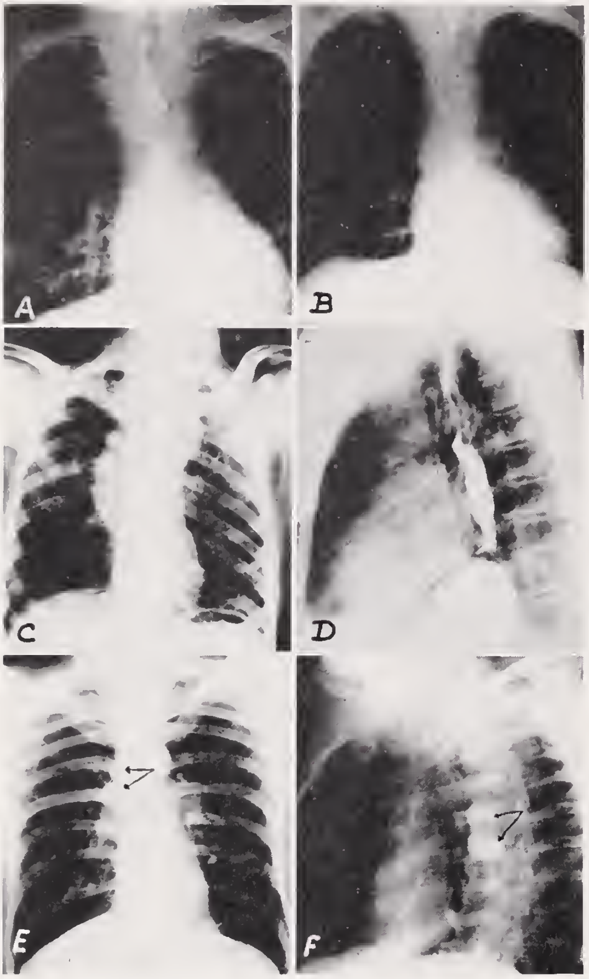

FIG. 1. Roentgenograms showing diseased conditions that originate outside the mediastinum. As these conditions develop they push into the mediastinum.

A. Conventional roentgenogram of the chest taken during the inspiratory period. Patient is a 51-year-old white man. The mass shown in the superior mediastinum is a substernal thyroid later proven by operation. Barium is shown in the esophagus.

B. Chest X-ray of the same patient taken a few minutes later but the patient is holding his breath and straining. Increased pressure thus created within the thorax has forced the substernal thyroid out of the superior mediastinum. This phenomenon is characteristic and strongly diagnostic of a substernal thyroid that is not fixed to surrounding structures. It indicates that the thyroid has descended into the mediastinum as it developed. It also demonstrates why most substernal thyroids can be removed through a typical cervical thyroid incision.

C. A paravertebral abscess from tuberculosis of the spine. Compare with figure 5, which shows a marked similarity. The abscess has pushed its way into the mediastinum.

D. An esophageal hiatal hernia of the diaphragm. There is barium in the esophagus and in the stomach which lies above the diaphragm in the mediastinum.

E and F. Two osteomas of 2 thoracic vertebrae as seen on a regulation posterioanterior and oblique roentgenographic view. At operation these osteomas arose from the lateral aspect of the body of the respective vertebrae.

deviated from the standard textbooks of anatomy and described an anterior and posterior division of the superior mediastinum created by a plane passing in front of the trachea and its bifurcation.

Pernkopf[2] reported that the relation of the mediastinal boundaries to skeletal parts is not always definite. He believed that the anterior overlapping of the pleural sacs cuts off the mediastinum from the sternum. The mediastinum is attached to the sternum in only 2 pleural free areas, the thymic and pericardial triangles. Pernkopf placed the posterolateral boundary at the level of the articulation of the heads of the ribs with the bodies of the vertebrae. It is implied by description that the paravertebral gutters are not a part of the mediastinum, and by the same token the ribs, their vertebral articulations and the vertebral bodies are not in the mediastinum; therefore, the spinal nerves as they emerge from the intervertebral foramina lie outside of the mediastinum.

It is difficult to describe the mediastinum in more detail, and it probably is not necessary. However, it is well to point out that the narrowest or thinnest (where the mediastinum is merely a septum) portion of the mediastinum is at the junction of the 2 pleural surfaces in the midline anteriorly at the sternal angle. At this location, according to Ochsner,[3] congenital communication between the pleural cavities may occur on rare occasions. The widest portion of the mediastinum is the middle mediastinum that surrounds the heart. The mediastinum is used as a pathway for structures that must find their way from the neck to the lung and/or abdomen or from the abdomen to the neck. It contains the heart and the blood vessels and nerves that enter and leave the heart. The contour of the mediastinum is determined by these structures within it.

Abnormal or diseased structures, such as neoplasms, infection, and other conditions not normally located in the mediastinum, may push into it, as, for example, a substernal thyroid, an esophageal hiatal hernia, or a tuberculous abscess from the vertebra (fig. 1). In this connection one can question whether neurofibromas originating from the spinal nerves actually ever enter the mediastinum. They do not originate in the mediastinum.

Abnormal or diseased conditions arising adjacent to the mediastinum may displace the mediastinum either by positive pressure or by negative pressure. Pleural effusion will push it away from the affected side, whereas atelectasis or absence of the lung will pull it to the affected side. Masses or neoplasms in adjacent areas may displace the mediastinum sufficiently to appear as arising in the mediastinum.

Abnormal anatomic structures or diseased conditions arising within the mediastinum may distort the structure considerably. On some occasions the mediastinum may be almost as large as the thorax. Neoplasms or masses arising within the mediastinum may displace it in a local area sufficiently to confuse the disease with one originating in the lung or adjacent structures.

From the clinical point of view it would appear that a discussion of mediastinal neoplasms must on certain occasions include a consideration of almost all masses encountered within the thorax.

CASES STUDIED

The material used in this work was obtained from the University Hospital, the Baltimore City Hospitals, and from the private patients of one of the authors. This study covers a period extending from 1941 through 1951, or an 11-year period. There was a total of 60 neoplasms. These mediastinal neoplasms can be classified as follows: (a) lymphatic tissue in origin, 28 (secondary carcinoma of the lymph nodes, 14; primary lymphosarcoma of the lymph nodes, 6; Hodgkin's disease of the lymph nodes, 3; thymic neoplasms, 3; thoracic duct cyst, 1; acute lymphatic leukemia of the lymph nodes, 1); (b) nerve tissue in origin, 7 (neurofibroma, 4; sympathogonioma, 1; ganglioneuroma, 1; and vagus nerve tumor, 1); (c) embryonic tissue in origin, 9 (teratoid tumor, 3; dermoid cyst, 3; other cysts, 3); (d) thyroid tissue in origin: substernal thyroid, 8; (e) undiagnosed mediastinal neoplasms, 8. The ages varied between 4 months and 72 years. During this time there were admitted 41,113 surgical patients to the 2 general hospitals, making the incidence of mediastinal neoplasms 0.097 per cent. The incidence in the practice of thoracic surgery is evidently much higher, since 1 of the authors treated 25 private patients during the same period. It is of interest that during this period there were diagnosed at the 2 general hospitals 141 patients with carcinoma of the esophagus, 274 patients with carcinoma of the lung, 17 patients with neoplasms of the lung other than carcinoma, 73 patients with mediastinal infections, 137 patients with hiatal hernia, 104 patients with thoracic aneurysms, 11 patients with aneurysms of the heart, and 16 patients with parasternal diaphragmatic hernias.

SYMPTOMS

The type and location of the lesion in mediastinal neoplasms are extremely variable. The symptoms vary greatly, and there may be none. In 9 patients in the present series there were no symptoms. The neoplasm may be found by routine roentgenogram or mass roentgenographic surveys of the chest.[4] Prows[5] in a study of 2,281 chest roentgenograms of 21 mm. size found mediastinal neoplasms in 2.26 per cent. Of course, the asymptomatic stage is the ideal time for diagnosis and surgical extirpation. The symptoms often are caused by pressure created upon a particular anatomic structure located within the mediastinum, such as cough when the trachea and main bronchi are involved, or edema and cyanosis of the face, neck and arms

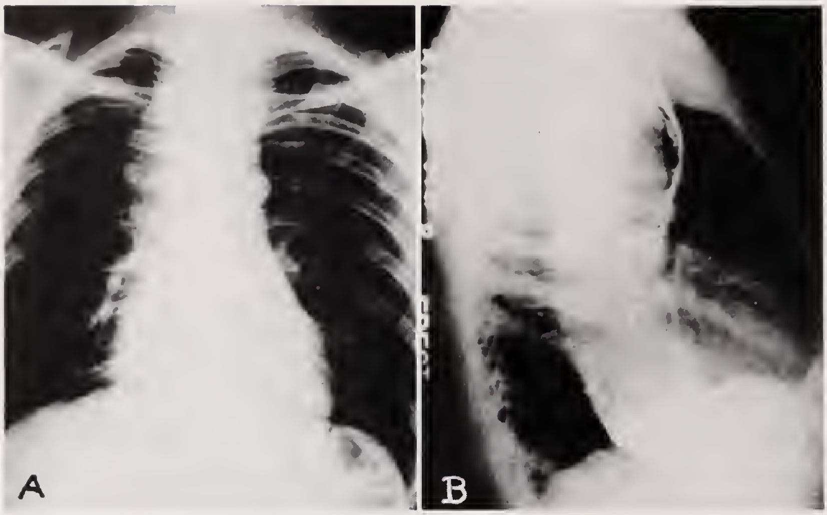

FIG. 2. Mediastinal enlargement caused by achalasia: A. To the right in the mid-thoracic region. B. Barium study of esophagus demonstrates the typical esophageal achalasia.

when the superior vena cava is obstructed by a mass. If there is a pathognomonic group of symptoms, it is described by the patient as awakening from sleep with a sense of impending disaster, shortness of breath, and a peculiar feeling in the chest relieved only by sitting upright in bed or arising and walking about. Always when seen by the doctor recovery of the patient has occurred. One patient of the group had these symptoms that progressed to the point where they occurred any time she attempted to lie flat in bed, either day or night. When the patient was forced to lie flat, there was no change in pulse, blood pressure or color, and there was no real difficulty with respiratory exchange. The subjective sense of recovery was prompt upon sitting up. In all such instances encountered the electrocardiagram was normal.

DIAGNOSIS

When considering a possible mediastinal mass one must first ascertain whether it arises within or without the mediastinum. It must then be determined whether it is a neoplastic or non-neoplastic mass. Of all the diagnostic methods and clues that will be discussed it should be clearly emphasized that the most

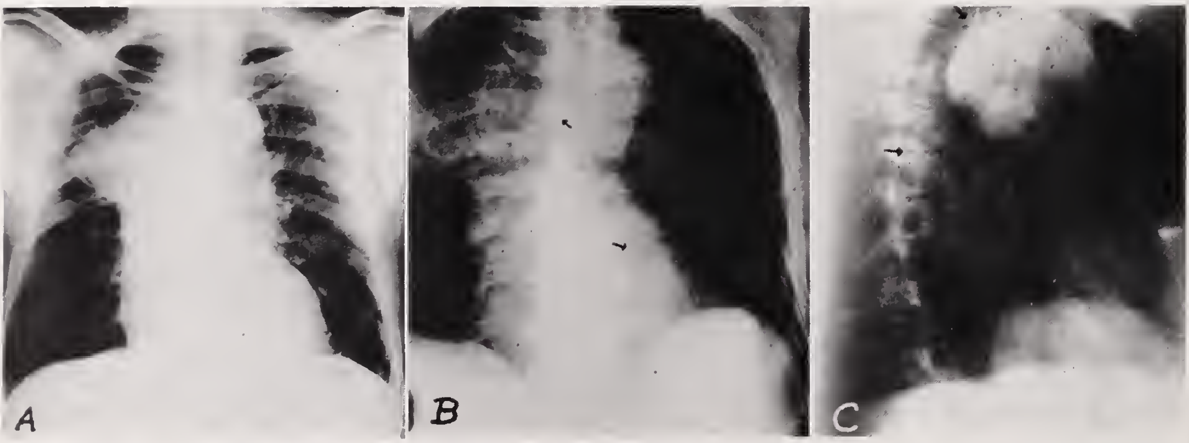

FIG. 3. Mediastinal aneurysm of ascending thoracic aorta as demonstrated by retrograde aortic catheterization and injection of an opaque medium.

A. Roentgenogram of chest showing mass in the upper part of the right pleural cavity. The mass must be differentiated from all types of masses that can occur in the thorax.

B and C. Catheter in the aorta and in the mass which proves the mass to be an aneurysm. An opaque media has been injected which makes the mass show more dense on roentgenogram.

important and useful diagnostic method is the exploratory thoracotomy with a pathologist available who can give a diagnosis from an examination of frozen-sectioned tissue. There are, however, masses in the mediastinum that are best treated without operation, for example, a small osteoma of a vertebra (fig. 1-E and F). Mediastinal infections or abscesses are most satisfactorily treated by simple operative technics less extensive than exploratory thoracotomy, and for these reasons accurate diagnosis is imperative.

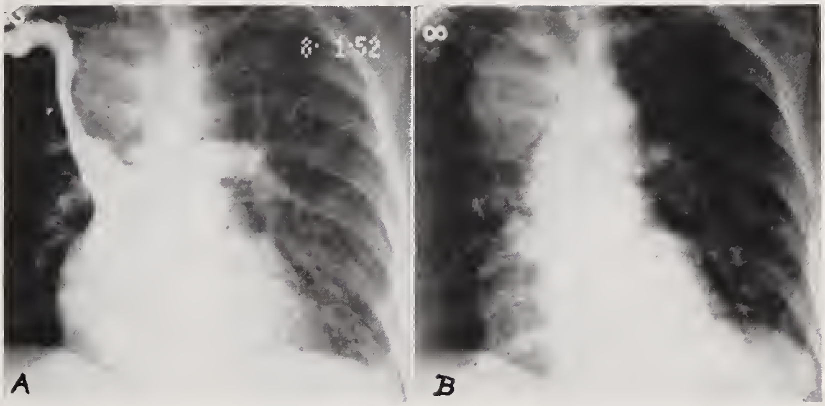

FIG. 4. Angiocardiography as an aid in the diagnosis of a mediastinal mass.

A. Superior vena cava displaced in a lateral direction by the mass. The mass is shown to be adjacent to the superior vena cava.

B. Opaque media has progressed beyond the right side of the heart and fills the left side of the heart, aorta and its large branches. The innominate artery is displaced slightly to the right by the mass. These 2 films prove the mass is not vascular in nature.

These roentgenograms are of a 38-year-old white woman who was entirely free of symptoms. A substernal thyroid was suspected even though a previous subtotal thyroidectomy had been done. The basal metabolic rate was normal. A typical collar type of cervical thyroid incision was made, but the mass could not be removed through this incision. The mass was not connected to the thyroid or to the thyroid blood supply. The chest was then opened through a typical posterolateral thoracic incision. The mass received its blood supply from the innominate artery and was thyroid. Perhaps this type should be classified as a thoracic thyroid.

Masses or neoplasms arising outside the mediastinum may be confused with those arising within by pushing their way into the mediastinum or by displacing the mediastinum. Masses that originate in the pleural cavity or its contents displace the mediastinum but do not gain access to the mediastinum proper. These are lung tumors, of which the majority are carcinoma or pleural tumors or collections of fluid. The masses or neoplasms arising from structures outside the pleural cavity but which are associated with the chest wall, neck or abdomen may displace the mediastinum, but sometimes they may actually migrate or push their way within the mediastinum (fig. 1). The differentiation will tax the ingenuity of the examiner, and often when all roentgenologic and other laboratory methods are exhausted the true nature or exact location of the mass is not known.

When the mass or neoplasm is thought to originate and lie within the mediastinum, one must determine whether it is neoplastic or non-neoplastic. If non-neoplastic it may be pus or fluid, it may be a congenital malformation of an organ or vascular element, or it may be a dilatation such as achalasia of the esophagus or an aneurysm of the heart or great vessels.

The inflammatory mass is usually determined by the presence of fever, leukocytosis, and other signs of infection. However, the patient with lymphosarcoma or Hodgkin's disease also may have fever. Lesions of the esophagus and intestinal tract usually can be determined by fluoroscopic and roentgenographic studies with or without contrast media (fig. 2). Esophagoscopy is of the utmost importance. Lesions of the heart and vascular elements often are easily determined by fluoroscopic and roentgenologic examinations, including angiocardiography, venography, and vascular and cardiac catheterization (figs. 3 and 4). The presence of a rim of calcification, the erosion of bone, or the existence of pulsations frequently distinguish the aneurysm. Planography and kymography are helpful roentgenologic methods. The use of pneumothorax, pneumoperitoneum, and even pneumomediastinum may on occasion be helpful.[6]

If the suspected thoracic mass is determined to be neoplastic and located in the mediastinum, the problem is narrowed down considerably. Neoplasms of the esophagus comprise a large group of mediastinal tumors but usually are not included in the group. Neoplasms of the trachea are extremely rare and are not included in the group. Neurofibromas arising from spinal nerves close to the vertebrae anatomically are not within the mediastinum but are considered clinically to be within the mediastinum. The substernal thyroid that receives its blood supply from a mediastinal source is a true mediastinal tumor. Neoplasms arising in the mediastinum generally can be classified as those arising from lymphoid tissue including lymph nodes, the thymus gland, the thoracic duct, nerve tissue, embryonic elements, thyroid and parathyroid tissue, connective tissue, and endothelial or mesothelial tissue.

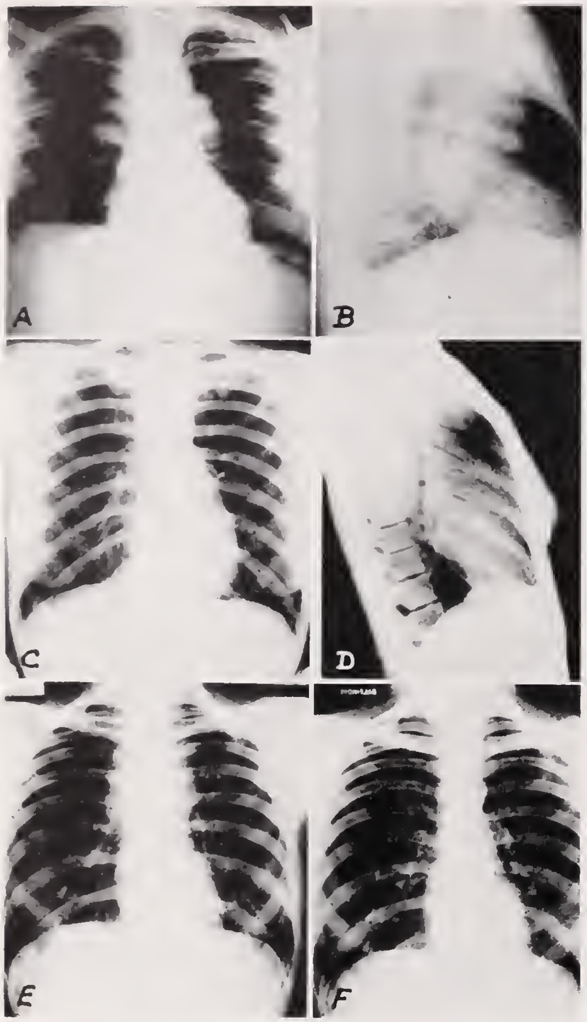

FIG. 5. Group of roentgenograms selected because of their similarity in appearance.

A and B. Boeck's sarcoid; the patient was a young adult colored male free of all symptoms. The diagnosis was made by biopsy of a distant lymph node; the tuberculin test was negative. There was a reversal of the albumin globin ratio.

C and D. Hodgkin's disease. The patient was a white woman 25 years of age who complained of malaise and weight loss. There were no abnormal findings except as shown by the roentgenogram. A biopsy was made through a cervical approach.

E. Lymphosarcoma. The patient was a 25-year-old white woman who when first seen had no symptoms. Before treatment was started she developed fever and complained of malaise. Tissue study has not been made. She was given a trial of roentgen ray therapy and responded favorably. The patient was then treated adequately by roentgen ray therapy.

F. Chest of same patient 26 months later, August 31, 1953. The patient is symptom-free and apparently well.

INCIDENCE AND TYPES

By far the greatest number of mediastinal masses have lymphatic tissue as their origin. These should be considered under lymph nodes, thymus glands, and lymphatic vessels including the thoracic duct.

The mediastinal neoplasms arising from or in lymph nodes are by far the most frequent of all mediastinal neoplasms. The secondary or metastatic lymph node neoplasm occurs much more frequently than the primary type. It is a difficult group to discuss, since in all instances it is a local manifestation of a general disease. The disease may conceivably have its origin in the mediastinum. In a study of such conditions it is important to point out that the number of patients with secondary mediastinal involvement is not accurate, since terminal studies are usually neglected. In the present series only those

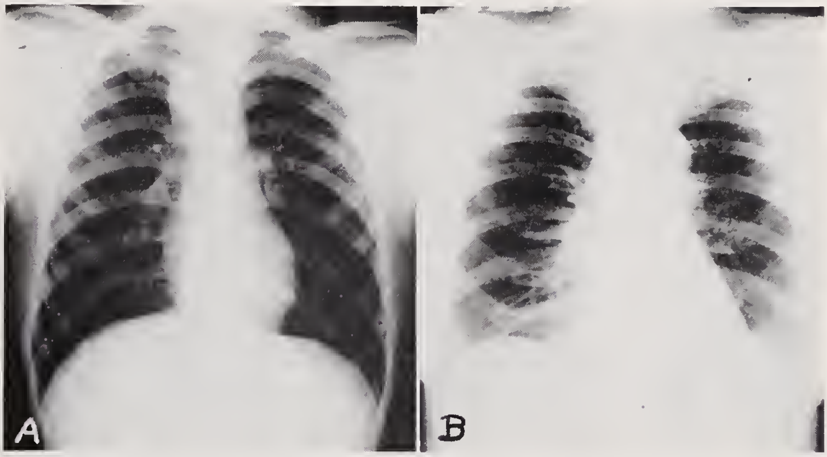

FIG. 6. Roentgenograms of chest.

A. Tuberculosis of lymph glands in the superior mediastinum. The patient was an 18-year-old white man. There was no other evidence of tuberculosis.

B. Chest of 63-year-old white woman whose first symptom was dysphagia and later dyspnea and then orthopnea. Esophagoscopy revealed intact esophageal mucosa, but constriction of the esophagus was caused by pressure from without. Bronchoscopy revealed an intact bronchial mucous membrane but constriction of the trachea was caused by pressure from without. Complete study of the patient failed to reveal the primary source of the suspected carcinoma. Thoracic exploration was carried out with misgivings. The mediastinum was fixed with metastatic glands to such a degree that the esophagus and trachea could not be freed. Biopsy revealed squamous cell carcinoma whose origin could not be determined. The patient died in the immediate postoperative period. A postmortem examination was denied. The location of the primary tumor is unknown. This patient illustrates the grave prognosis that often is encountered in exploration of neoplasms of the mediastinal lymph glands when there are signs of tracheal obstruction.

patients who presented mediastinal involvement as a diagnostic problem are being considered. Neoplasms of lymph nodes of the mediastinum usually will be found in the midportion, front to back, of the mediastinum. The characteristic multiple nature or the nodular appearance (fig. 5) distinguishes the group from all other mediastinal neoplasms, which are characterically solitary. Multiple mediastinal masses must be distinguished from inflammatory nodes, of which the most common is tuberculosis (fig. 6-A). There is a question whether Boeck's sarcoid should be classified under inflammatory or neoplastic processes (fig. 5-A and B). In the true neoplasms one finds the metastatic carcinoma (fig. 6-B) and the primary lymphoma group of lymphosarcoma and Hodgkin's disease (fig. 6).

Metastatic carcinoma of the mediastinal lymph nodes occurs much more frequently than the primary lymph node involvement. In the present series there were 14 secondary and 9 primary lymph node malignant lesions. In the metastatic carcinoma group a thorough search will often reveal the silent, concealed primary growth or the obvious primary tumor. It is only rarely that careful study and examination do not reveal the primary growth. In such cases they may be confused with the primary lymphomas. Generally the metastatic growth will be smaller, and if serial roentgenograms are available the secondary type will be found not to increase in size as rapidly as the primary. Objective and

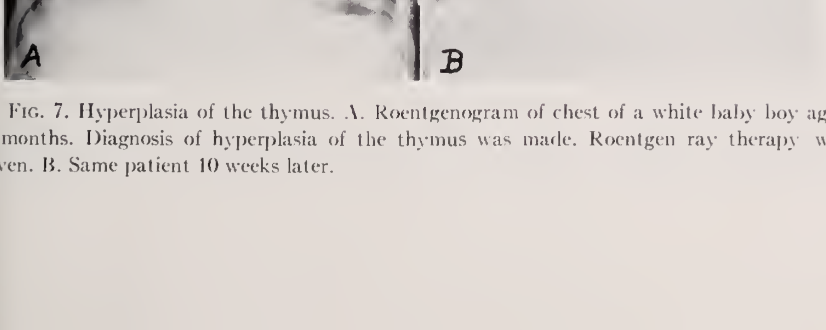

FIG. 7. Hyperplasia of the thymus. A. Roentgenogram of chest of a white baby boy aged 4 months. Diagnosis of hyperplasia of the thymus was made. Roentgen ray therapy was given. B. Same patient 10 weeks later.

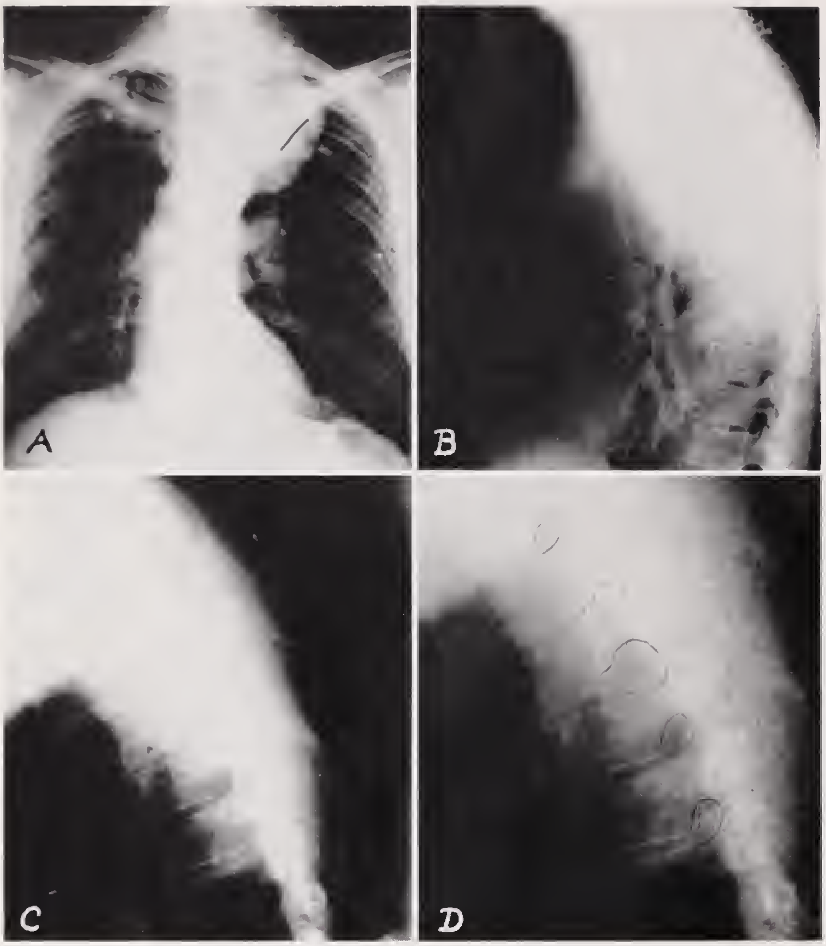

FIG. 8. Neurofibroma of the mediastinum (vertebral gutter).

A and B. Roentgenograms showing the mass in the superior and posterior aspect of the chest or mediastinum. The smooth outline and the posterior position would lead to a suspicion of neurofibroma of the mediastinum (vertebral gutter).

C. Roentgenogram taken to demonstrate the intervertebral foramen. Close inspection will show an enlarged intervertebral foramen.

D. Photographic enlargement of "C" with the region touched up with ink lines.

Enlargement of the intervertebral foramen is characteristic of neurofibroma of a peripheral nerve, but is not absolutely diagnostic. This patient was a 47-year-old white male. The tumor did not extend into the neural canal. The pathologic diagnosis was neurofibroma.

subjective symptoms may be much the same in both types.

The primary lymphoma is the most common of all mediastinal neoplasms except the metastatic carcinoma. It may be distinguished by its multiple or nodular appearance and is usually found in the midportion, from front to back, of the mediastinum. A careful search may reveal a palpable lymph node elsewhere, biopsy of which will reveal the true nature of the disease. In the beginning the patient with lymphosarcoma is not likely to be sick, whereas the patient with Hodgkin's disease usually shows early systemic reactions. The temperature may be elevated. There may be an abnormally high white blood cell count. There were 6 patients in the present group with lymphosarcoma and 3 with Hodgkin's disease. There was 1 child with prominent mediastinal lymph node enlargement from acute lymphatic leukemia.

The thymus may be concerned in mediastinal tumors.[7] Hyperplasia in infancy must be considered. Myasthenia gravis may be associated with hyperplasia or tumors of the thymus.[8] Cysts of the thymus have been described. The malignant tumors are of the lymphosarcoma or carcinoma type. One patient with carcinoma of the thymus was encountered in the present series. This patient showed superior vena cava obstruction. Extirpation of the mass with the lung and superior vena cava was accomplished, but the patient died shortly after completion of the operation. There was 1 patient with hyperplasia of the thymus (fig. 7) and 1 with lymphosarcoma of thymic origin.

In the group there was 1 patient with a chylous type of mediastinal cyst. Proof of its origin from lymphatic vessels or the thoracic duct is absent, but from all appearances it did have such an origin.

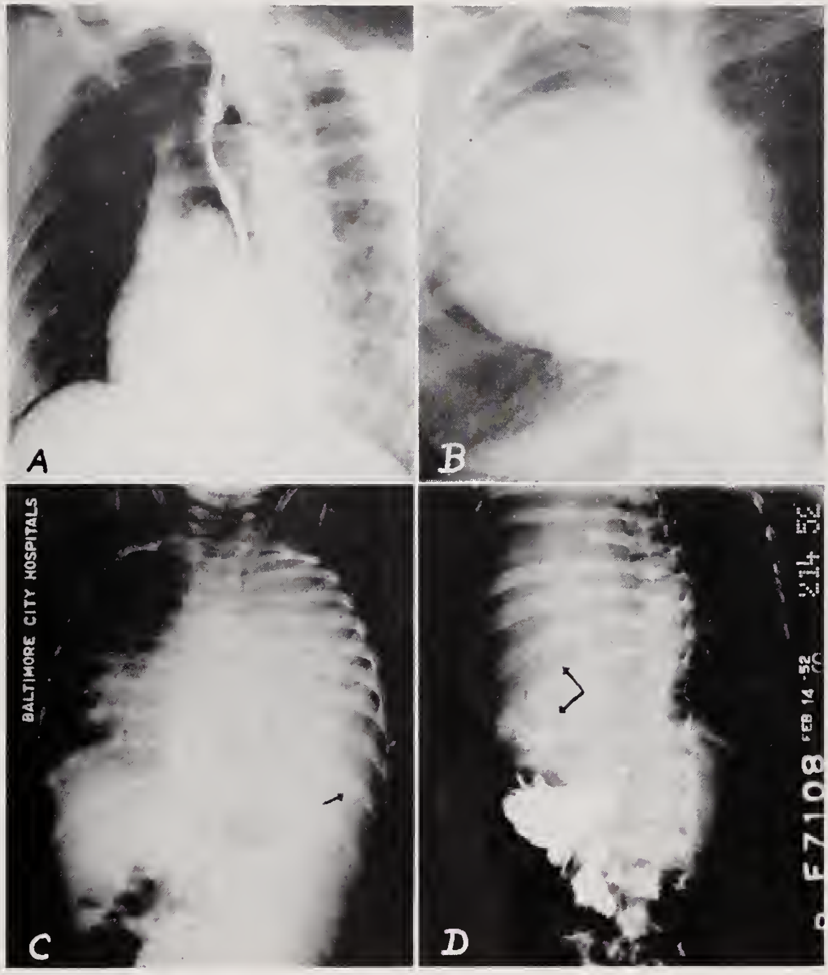

Fig. 9. Mediastinal dermoid and teratoid tumor.

A. Roentgenogram of chest showing a mediastinal mass suspected of being a dermoid cyst. The patient was a white woman 38 years of age; she refused operation.

B. Same patient as A but 11 months later. Patient developed considerable dyspnea in the interval. The mass was removed and the patient made an uneventful recovery. She died about 4 years later from a primary carcinoma of the uterine cervix. The mediastinal mass was a dermoid cyst.

C and D. Roentgenograms of chest of a 17-month-old white boy, who was admitted to the hospital because of a large palpable mass in the left upper quadrant of the abdomen. At one time the chest findings were thought to represent metastatic involvement from the primary abdominal malignancy, most likely adrenal in nature. The presence of bone in the mass should have immediately made the diagnosis evident; it did at a later date. The diagnosis was made when the chest was opened in the hope of relieving dyspnea and establishing a pathologic diagnosis by tissue study. Later the mass was removed and the patient made an uneventful recovery. The pathologic diagnosis was teratoid tumor. The palpable abdominal mass was actually the mediastinal teratoid. The teratoid tumor had become so large that it inverted the left diaphragm and presented in the left upper quadrant of the abdomen.

The neurogenic tumors arising from the spinal nerves or from the autonomic nervous system make up a large number of so-called mediastinal neoplasms. They are the most common of the posterior mediastinal tumors. We are not sufficiently experienced in pathology to distinguish the various types of neurogenic tumors encountered. The tumors noted have been either from peripheral spinal nerves or from the sympathetic trunk. In only 1 case has a tumor of the vagus nerve been encountered; it was found upon thoracic exploration for another cause and was not revealed on roentgenographic examination of the chest. No other neoplasm of the parasympathetic nerves has been found. Neurogenic tumors of the sympathetic trunk have occurred, but a neurogenic neoplasm arising from branches of the sympathetic trunk or small mediastinal sympathetic nerve fibers has not been encountered. Failure to find neurogenic tumors except those arising from peripheral spinal nerve trunks or from the sympathetic trunk accounts for their characteristic posterior position. These neoplasms are always closely associated with the region of the vertebral column or are in the vertebral gutter (fig. 8). They are usually solitary.

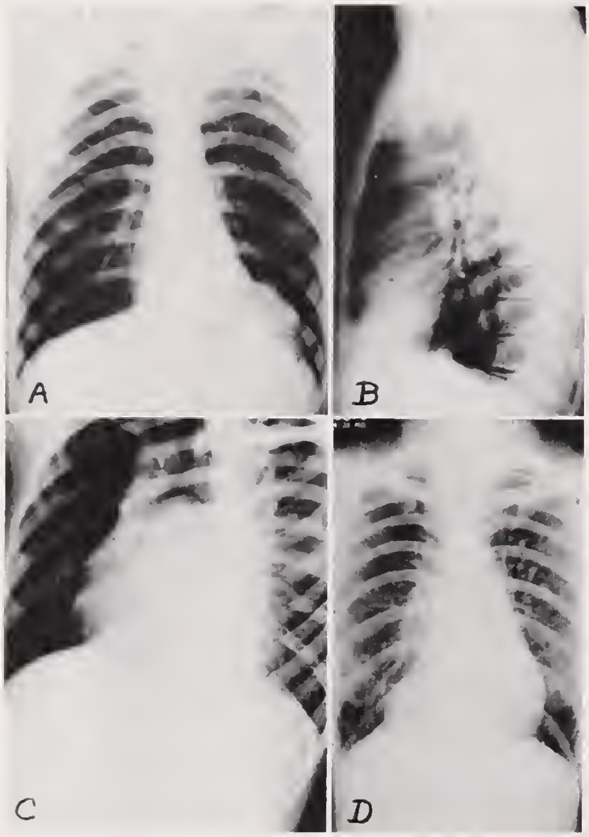

FIG. 10. Cysts of the mediastinum: A and B, coelomic; C, bronchogenic; D, pericardial cyst whose fluid communicated with the pericardial fluid. All of these occurred in young adults and were removed without difficulty.

If there is enlargement of an intervertebral foramen (fig. 8-C and D), it is often diagnostic of a neurogenic tumor arising from a peripheral spinal nerve. However, other types of neoplasms and even echinococcus cysts may be of the hour-glass type and be present in an identical manner and location.[7] This finding should always be sought in tumors found in this location. If there is enlargement of the intervertebral foramen there may be tumor tissue within the intervertebral foramen and extending in an hour-glass shape both inside the neural canal and in the paravertebral region. Only 2 such cases have been encountered in this series. In no patient with mediastinal neurogenic neoplasm have there been demonstrable neurologic symptoms or changes, except in 1 patient whose neurologic findings from spinal cord compression caused her to seek medical aid. The patient had an hour-glass type of neurogenic tumor presenting both inside the neural canal and in the thoracic region. Kent[9] reported the occurrence of vocal cord paralysis and Horner's syndrome. The Pancoast syndrome[10] is not caused by mediastinal neoplasms. In the present series there have been 7 patients with neurogenic mediastinal neoplasms. In only 1 of these patients was there a malignant degeneration. Kent[9] reported 18 patients and from the literature collected 105 patients with intrathoracic neurogenic neoplasms. In these he found malignancy in 41 and 37 per cent respectively. Malignancy in mediastinal neurogenic tumors was found in 19 per cent of 21 patients by Efskind,[11] and he compared this with 3.4 per cent of 29 patients reported by Blades.[12]

The mediastinal tumors arising from embryonic tissue usually are made up of simple dermoids or teratoid tumors, bronchogenic cysts, coelomic cysts, and simple cysts arising from the pericardium or pleural surfaces. The simple dermoids or teratoid tumors are usually in the anterior mediastinum. They are the most frequent tumor mass found in the anterior mediastinum. They are single but may be multilocular or lobulated. They arise in the midline but by growth may push more to one side than the other. If bone is shown in the mass, and it should always be sought, it is diagnostic of a teratoid tumor. When these teratoids or dermoids contain fluid, there may be fat present which will cause the fluid to separate in 2 layers, thus giving a fluid line.[13] There have been 3 patients with dermoid cysts and 3 with teratoid tumors (fig. 9). In 1 case the content was coughed up. In another case the presenting symptom was a left upper quadrant abdominal mass (fig. 9-C and D). Study finally revealed the true diagnosis. In the present series there were no malignant tumors. Rusby,[13] however, reported malignancy in 12.9 per cent of cases.

A bronchial cyst was encountered in only 1 patient (fig. 10-C). Blades[14] has shown this to be the second most common mediastinal neoplasm discovered in young adults of Army age.

A pericardial cyst was found in only 1 patient (fig. 10-D). This cyst arose from the serous pericardial lining and protruded through a small opening in the fibrous pericardium. It was easily compressible, and its clear fluid contents could be readily forced into the pericardial cavity.

A coelomic cyst was present in only 1 patient (fig. 10-A and B). Acute spontaneous hemorrhage from a hemangiomatous area in its lining wall caused acute pain and forced the patient to seek medical attention. The cyst was wedged in the crevice between the sternum, pericardium and diaphragm. It could easily have been confused with a parasternal hernia.

The question of substernal (fig. 11) or mediastinal (fig. 4) thyroid is important to the problem of mediastinal tumors. Eight such patients were seen in this series. It is obvious that thyroid enlargements associated with palpable cervical thyroid glands present no real problems in diagnosis. This type of substernal thyroid is not

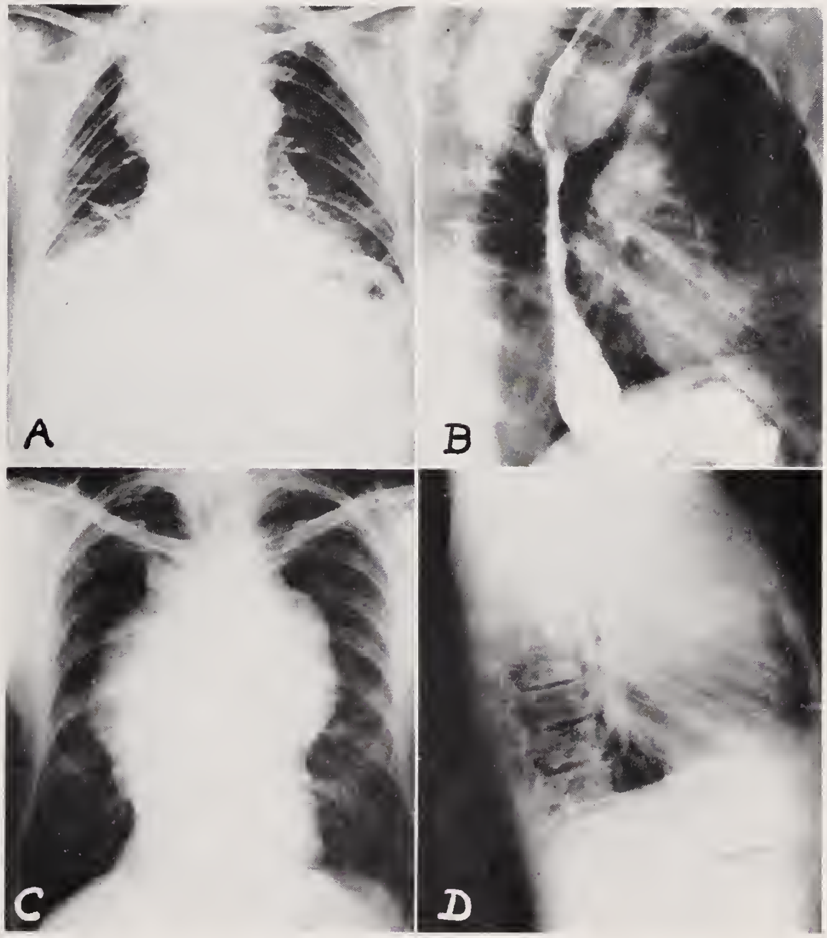

FIG. 11. Substernal thyroid.

A and B. Roentgenograms of a 56-year-old white male.

B. Note that the mass is between the esophagus and trachea. The patient had signs of superior vena cava obstruction, a Horner's syndrome, dyspnea but no dysphagia. There were no signs of thyroid dysfunction. The mass was removed through a typical cervical thyroid incision without difficulty and the patient made an uneventful recovery. It arose only from the right lobe of the thyroid and had a typical thyroid blood supply.

C. and D. Roentgenograms of a 52-year-old white male who complained of gradually but relentlessly increasing dyspnea over a 2 or more-year period.

D. Note that the mass is anterior to the trachea. Elsewhere he had received 2 separate courses of roentgen ray therapy. Symptoms were not relieved and the gradual continued growth of the mass was not deterred. Carcinoma of the thyroid was suspected. There were no metastases. The thyroid in the neck could not be palpated. The mass was removed through a sternal splitting incision without surgical difficulty or accident. The mass extended from the sternal notch to the diaphragm and of course extended into both pleural cavities. It was anterior to the trachea and heart. Unfortunately, the patient died a few hours after completion of the surgery. The diagnosis was carcinoma of the thyroid.

This patient demonstrates the dangers concerned in giving roentgen ray therapy for mediastinal masses that have not been accurately diagnosed. In a mass of this type even a trial with 1,000 roentgen units is not indicated; however, had it been used and when no response was shown, the patient could have been offered surgery. He could have been offered surgery almost 2 years earlier. At that time the mass was much smaller and undoubtedly the patient was in better physical condition. He might have survived operation.

often considered with mediastinal tumors and is therefore not included in this discussion. There are, however, substernal thyroids which are found only on routine examination of the chest by roentgenography. No enlargement of the thyroid in the neck is observed and there are no thyroid symptoms. Rives[15] described these as complete substernal goiters and as aberrant mediastinal goiters. The substernal thyroid in 1 patient of this series had the blood supply arising from the innominate artery (fig. 4). In another case the thyroid was posterior to the esophagus in the superior mediastinum. In 1 patient the substernal thyroid presented between the trachea and the esophagus (fig. 11-A and B). One patient had a slightly lobulated transparent thin-walled cyst containing water-clear fluid. This was from the lower aspect of the right side of the thyroid but was located in the superior mediastinum. It caused displacement of the trachea but presented no other discernible change in roentgenograms of the chest. Wood[16] described a similar case.

When presented with the necessity of distinguishing a substernal thyroid the effects of abnormal thyroid function should be considered. The presence of a palpable cervical thyroid should be sought. The ability to palpate the upper mediastinal mass must be carefully explored. Motion of the upper mediastinal mass by deglutition or straining shown either by palpation or roentgenographic study is highly diagnostic of thyroid (fig. 1-A and B). Deviation of the trachea is an important radiographic finding, but when the substernal thyroid is bilateral there may be no deviation, as shown in 1 case. Compression of the trachea is an important finding. There is evidence that radioactive iodine studies will reveal whether or not the superior mediastinal mass is thyroid.[6, 17-19] The test is not conclusive when negative;[18-21] when the test is positive it appears to be related to the functional activity of the thyroid.[22]

Parathyroid tumors presenting in the superior mediastinum have not been encountered in this series; however, they have been reported by several authors.[23-26] Cope[27] reported on 54 patients with 58 parathyroid adenomas, of which 11 were in the anterior mediastinum and 5 in the posterior mediastinum.

In the present series there were no neoplasms of connective tissue origin or of endothelial or mesothelial origin; however, such tumors have been recorded by several authors[12, 14, 28, 29] and described most adequately by Heuer.[7] In the present series there was 1 questionable primary sarcoma of the mediastinum.

It is difficult to describe the 8 neoplasms of the mediastinum that are placed in the group considered undiagnosed neoplasms. Three of these did not have exploration or treatment, and the end result is not known. Four of the patients had exploratory thoracotomy with biopsy, but the pathologic reports were vague. One patient in the group had a large mediastinal neoplasm that was excised adequately. The pathologic diagnosis was neoplasm of thymic or nerve sheath origin. She is alive and well at present, approximately 7 years later.

PROGNOSIS

It is difficult to indicate clearly the prognosis of a heterogeneous group of tumors found in the mediastinum. The malignant potentiality is great; however, in an undiagnosed mediastinal mass it is less likely to be malignant than an undiagnosed lung tumor. If the lymph node neoplasms, which are all malignant, are removed from the mediastinal tumors, the chance of malignancy is reduced considerably. In no instance can the mediastinal neoplasms be expected to undergo spontaneous remission. The mediastinal neoplasms can be expected to gradually increase in size and finally crowd the vital thoracic organs to a point that is incompatible with continued function, or the malignant neoplasm may cause death by generalized metastasis. In the present series of patients there were 12 who had thoracic exploration. In these the diagnosis was lymphosarcoma in

1 case, 7 metastatic carcinomas were identified, and in 4 patients the exact diagnosis was indefinite in spite of pathologic study. Four patients died as a result of the exploration. In 25 patients the mediastinal tumor was extirpated surgically, and in this group 2 deaths occurred. Death occurred in 1 patient with carcinoma of the thymus with superior vena caval obstruction, as has been described previously. The second death was that of a patient who had an extremely large substernal thyroid carcinoma (fig. 11-C and D). The diagnosis was suspected before operation. The mass was removed successfully, but the patient died a few hours after operation. In the remaining 23 patients the diagnosis was determined by biopsy of the distant nodes, a trial of roentgen therapy, or by autopsy.

TREATMENT

Surgical extirpation of the mediastinal neoplasm is the treatment of choice except in cases of multiple primary and secondary malignant lymph nodes. In primary malignant disease of the lymph nodes roentgen-ray therapy is the treatment of choice. In secondary malignant disease of the lymph nodes such therapy is not likely to be helpful.

If secondary carcinoma, lymphosarcoma or Hodgkin's disease of the mediastinum can be diagnosed by distant node biopsy, thoracic exploration is, of course, contraindicated. When the neoplastic involvement is extensive, thoracic exploration may be dangerous, as shown by 4 deaths in 12 patients thus explored. If a diagnosis of lymphosarcoma or Hodgkin's disease is clinically evident by the presence of multiple nodes involved and clinical symptoms indicating such a diagnosis, thoracic exploration is not desirable until a trial of roentgen-ray therapy is made.[1] The small amount of radiation used will in no way affect the disease if it is not lymphatic.[28] The tumor will not be made more adherent; operation will not be more difficult; and the time involved surely will not be important in prognosis of other mediastinal masses unless the patient is in acute distress when first seen. Diseases other than lymphatic in character will not be made to disappear or regress with such a small amount of radiation therapy, since only 1,000 roentgen units need be given and response can be expected in 14 to 21 days.[30] If, on the other hand, a single node is involved by primary or secondary malignancy, surely extirpation cannot be wrong. A solitary malignant lymph node was not encountered in this series.

In the surgical extirpation of the substernal thyroid the incision of choice is the typical collar incision of the usual cervical thyroidectomy. If there is a questionable diagnosis which points strongly to the substernal thyroid, it is best to explore through the typical cervical thyroid incision, since it is a simple and easy approach both for the patient and for the surgeon. If the mass is thyroid with cervical blood supply it can be safely removed. For the large substernal thyroid Clute[31] advised rupture of the capsule to permit the semisolids to run out, and later Lahey and others[15, 20, 32] described the technic of evacuating the semisolid colloid central portion to reduce the size. If the mass is not thyroid or if it is thyroid that has a thoracic blood supply, obviously such exploration will fail and the thoracic exploration must be used immediately or at a second operation. On the other hand, a typical substernal thyroid with cervical blood supply cannot be removed adequately and safely through a thoracic approach.

There is always a question concerning the surgical approach to mediastinal neoplasms. In the present series only the typical posterolateral thoracic approach has been used with few exceptions. In 1 patient in whom a large substernal thyroid with carcinomatous degeneration was suspected a sternal splitting incision was used. The prone position of the patient and a posterolateral incision have been used on patients with suspected neural canal extension of neurogenic mediastinal tumors. This position makes simultaneous laminectomy more easily accomplished.

Summary and Conclusions

The anatomy of the mediastinum has been reviewed. A question is raised concerning the paravertebral gutters. Anatomically these regions are not a part of the mediastinum, but clinically they are often considered to be so.

Consideration of mediastinal tumors includes in certain selected conditions a differential diagnosis of all space-occupying lesions that occur in the thorax.

In considering mediastinal neoplasms, tumors of the esophagus and trachea are usually excluded. Neurofibromas in the paravertebral region and certain substernal thyroids are included. Thus, the neoplasms of the mediastinum can be classified as those neoplasms arising from (a) lymphatic tissue, (b) nerve tissue, (c) embryonic elements, (d) thyroid and parathyroid tissue, (e) connective tissue, and (f) endothelial and mesothelial tissue.

For solitary mediastinal neoplasms surgical extirpation is the treatment of choice.

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AMENORRHEA IN THE ETIOLOGY OF STERILITY*

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A BARREN marriage does not usually arise because of reproductive defects in only one partner, but is generally the result of the sum total of several factors, often minimal, in both husband and wife. Bearing in mind the physiologic aspects of conception, as well as the multiple reasons for its dysfunction, the physician must seek to uncover the following etiologic facts in his study of a barren couple: gross pelvic disease, male infertility, errors of cervical insemination, tubal occlusion, and endocrine faults in the female. The precise incidence of any one of these in the multiple causation of barrenness varies with the type of practice conducted by the physician. In a recent analysis of my private practice, it was determined that 18 per cent of 245 sterile women presented evidence of an endocrine cause of the sterility; 10 per cent showed a fault of ovulation, and the remaining 8 per cent had amenorrhea.[1]

The complete dependence of reproduction on the integrity of the endocrine system is an accepted fact. From the standpoint of fertility, normal menstruation—rhythmic dismantling of an estrogen-primed and progesterone-modified endometrium, as determined by premenstrual biopsy or curettage—connotes an intact endocrine system. Deviations from the normal point to disruption of the pituitary-ovarian-uterine mechanism. For purposes of diagnosis, endocrine factors in the female partner may be divided into two groups, (1) abnormalities of menstrual rhythm, namely, amenorrhea and dysfunctional uterine bleeding, and (2) anovular menstruation. It is impossible to consider our present knowledge of menstrual disorders, a field encompassing an enormous section of medical knowledge and theory, in a single essay. For that reason the discussion to follow deals with cessation of the menstrual cycle which is loosely termed "of endocrine origin" and which may present itself in barren women as either oligomenorrhea or amenorrhea.

Amenorrhea is an obvious handmaiden to sterility. Its presence permits the assumption that an endocrine derangement requiring treatment exists in the female partner. Of itself, amenorrhea acquires importance in a barren woman for two reasons; namely, it is a factor in the causation of barrenness and it is associated with faulty reproduction if pregnancy should occur. Persistent amenorrhea causes sterility through lack of ovulation and continuing atrophy of the uterus, both of which are serious impediments to conception. Of somewhat greater significance, even though not sufficiently emphasized, is the fact that women who conceive despite the presence of amenorrhea have abnormal reproductive careers.[2] It is therefore essential, even if the amenorrhea does not prohibit conception, that it be corrected in the interest of obviating pregnancy wastage.

Classification of Amenorrhea

Primary amenorrhea is the term employed to describe absence of menstruation from the time of puberty. In such a patient there has been no single menstruation. It is not a common entity, appearing infrequently as a cause of barrenness in comparison with the more usual secondary amenorrhea.

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Secondary amenorrhea connotes absence of menstruation in a woman who had previously experienced some type of menstrual cycle. Such dysfunctional secondary amenorrhea may be of short or long duration. For purposes of clinical grouping it is our custom to employ the term "amenorrhea" when the interval between periods is 4 or more months and to use the expression "oligomenorrhea" when the menstrual intervals are less than 4 months. In my experience, oligomenorrhea is 3 times more common than amenorrhea in barren women.

DIFFERENTIAL DIAGNOSIS OF AMENORRHEA

The causes of primary and secondary amenorrhea and the minor variant of secondary amenorrhea, oligomenorrhea, while undoubtedly similar, are not past dispute. Despite the store of information resulting from investigations of anatomists, physiologists, and chemists, a distinct etiology and a standard method of treatment are still lacking. The proper approach to the differential diagnosis of amenorrhea requires consideration of organic disease as a possible cause, a procedure which embodies thorough understanding of the chain of organs involved in the mechanism of normal menstruation, namely, the anterior hypophysis, ovaries, uterus, and the associated endocrine glands, thyroid and adrenal. This demands careful history-taking and thorough physical examination. In certain instances, it is also necessary to resort to special X-ray examinations of the skull, vertebrae, and renal areas. Occasionally pneumoperitoneum and culdoscopy are useful in differential diagnosis. Thus, it is possible to eliminate, prior to initiating therapy in an amenorrheal woman, the presence of thyroid adenoma, pituitary tumor, ovarian neoplasm, adrenocortical lesion, and, not the least to be mentioned, some form of pregnancy. It is imperative to remember that a woman may conceive during the course of amenorrhea. It is frequently necessary to employ biologic tests in order to be certain that pregnancy is not the cause of the amenorrhea. Thus, the finding of an enlarged uterus, suggesting early pregnancy, in a woman who has not menstruated for 6 months must not be ignored. If the pregnancy test in such an instance is positive, it may be assumed that the patient would have completed a menstrual cycle, thus terminating her amenorrhea, had she not become pregnant.

Following exclusion of an organic cause it is of interest to determine whether or not the amenorrhea is of pituitary origin by repeatedly assaying the blood or urine for gonadotropin. If there is no measurable urinary output of pituitary gonadotropin, it may be inferred that the basic disorder lies within the anterior hypophysis or its controlling hypothalamic area. If, on the other hand, there is excessive excretion of pituitary gonadotropin, the characteristic expression of a hypogonadal state, it may be concluded that the amenorrhea is of ovarian origin. It is not always feasible, however, to follow such a rational course in clinical practice. For practical purposes it is often necessary to determine the probable etiology of amenorrhea by means of the patient's response to therapy. It is possible, in this fashion, to observe the responsiveness of the endometrium to estrogen and progesterone, and to perceive the effect of combined steroids on the menstrual function.

TREATMENT OF PRIMARY AMENORRHEA

A mechanical cause of primary amenorrhea, such as intact hymen, stenotic cervix, etc., is easily recognized by means of physical examination. There remains the small group of amenorrheal women who have never experienced menarche because of either serious endocrine disorder or failure of uterine development. The small, infantile, hypoplastic uterus confronting the physician in the latter circumstance, an organ which fails to respond to estrogen by bleeding, is a prime example of developmental disturbance. The lack of uterine growth probably reflects failure of vascular development. The minuteness of the vasculature of the immature uterus, leading to profound hypoplasia of the several uterine components, makes it difficult to correct and offers a poor prognosis, unless the patient is seen at any early age. I have had the privilege of attempting to treat 5 barren women who had primary amenorrhea. The only one who responded to many months of cyclic steroidal therapy was the sole patient under 20 years of age.

The major problem to be solved when faced with an example of primary amenorrhea is to determine whether or not it is of uterine developmental origin. Failure of the uterus to bleed following administration of large, prolonged doses of estrogen and progesterone implies that the avascular endometrium cannot be made to grow and to desquamate. If administration and withdrawal of ovarian steroids does result in uterine bleeding, the responsive endometrium may be considered to be free from developmental defect, and the cause of the primary amenorrhea may be ascribed to endocrine dysfunction. The type of dysfunction should be determined by means of gonadotropin assays. A high level of gonadotropic hormone excretion by a woman with primary amenorrhea indicates ovarian failure. The degree of ovarian development may be estimated by culdoscopic visualization.

TREATMENT OF SECONDARY AMENORRHEA

The proper approach to the management of secondary amenorrhea in a sterile woman is, as in primary amenorrhea, determination of its etiology. This may be accomplished by means of physical examination, aided by assays for pituitary gonadotropin and adrenocortical steroids. When such assays are not feasible, an estimate of the primary site of disorder may be made by means of the patient's response to therapy. The latter should include correction of abnormal living conditions, prescription of a proper diet, cure of any existing anemia, evaluation of the patient's thyroid function with a view to eliminating hypothyroidism which may be masked, trial administration of progesterone alone, cyclic usage of estrogen and progesterone, injection of gonadotropins for amenorrhea known to be the result of pituitary failure, employment of surgery in instances of palpably polycystic ovaries, cautious exhibition of cortisone in selected patients, and low-dosage irradiation to the pituitary gland and ovaries on an empiric basis.

Diet. The role of dietary supplements in correcting amenorrhea is not understood. Evidence has accumulated from animal experiments[3] and from observations of temporarily underfed women[4] to indicate the value of a basic minimum intake both of animal proteins and vitamins.

Thyroid. The importance of subclinical hypothyroidism, particularly in younger women, must not be underestimated. Even if an amenorrheal woman presents no clinical signposts of hypothyroidism, it is best to evaluate her thyroid function, particularly if the amenorrhea is of long-standing origin. This is especially true of the patient who has had oligomenorrhea from the time of the menarche which gradually merged into amenorrhea. The use of basal metabolic rate determination, the estimate of protein-bound iodine of the blood serum, determination of the blood cholesterol level, and a tracer study of radioactive iodine are necessary for proper evaluation of the patient's thyroid function. When hypothyroidism is demonstrated, it is obvious that administration of desiccated thyroid substance up to the degree of tolerance is required.

Progesterone. Administration of progesterone alone as the initial step in management of a patient with secondary amenorrhea is logical, because its effectiveness presupposes the presence of sufficient endogenous estrogen to have caused preliminary vascularization of the endometrium. If bleeding occurs following progesterone therapy alone, it may be concluded not only that the endometrium is adequate but also that some degree of ovarian function is present and that estrogen is being produced. Progesterone may be administered by means of either parenteral or oral therapy. The parenteral dose should be 25 mg. intramuscularly every other day for a total of 4 injections (100 mg.). When given orally, the dose should be either 25 mg. of the sublingual tablet twice daily or 10 mg. of the anhydrohydroxy-progesterone tablet 6 times daily for 1 week. If bleeding follows such progesterone therapy, subsequent treatment may consist of either monthly repetition of the progesterone course or low-dosage irradiation (*vide infra*) in an attempt to create cyclic function of the ovary and pituitary gland. If bleeding does not follow administration of progesterone alone, the next step in therapy should be the use of both estrogen and progesterone.

Estrogen and progesterone. Such dual steroid therapy is the mainstay in the management of secondary amenorrhea, since it is both substitutive and stimulative treatment. It substitutes for a failing ovary and at the same time serves as a stimulant to the pituitary gland through the mechanism of cyclic administration and withdrawal. The ovarian steroids may be administered by one of several patterns. They may be given either together, as a combined injection, or separately in consecutive manner. In the former method, the amenorrheal patient may be given a combined intramuscular injection of 2.5 mg. of estradiol benzoate and 12.5 mg. of progesterone on 2 successive days. Using the consecutive style, one may administer 1.5 mg. of estradiol benzoate intramuscularly every third day for 5 doses and follow immediately with 5 daily injections of 10 mg. of progesterone. Such dual therapy, combined or consecutive, should be repeated for 3 months in succession.

The ovarian steroids may also be orally administered in the following fashion: Estrogen is given for 3 weeks in a daily dose of 0.5 mg. of ethinyl estradiol, or of 2 mg. of diethylstilbestrol, or of 7.5 mg. of estrone sulfate. During the final week of estrogen therapy (i.e., after estrogen has been taken for 2 weeks), oral progesterone is also given in the form of anhydrohydroxy-progesterone, the dose being 10 mg. 6 times daily for 1 week. In this schedule, both estrogen and progesterone are discontinued at the conclusion of the third week of therapy. The course of treatment should be repeated for 3 successive months, each beginning on the third day of induced bleeding.

It is also possible to employ estrogen and progesterone in tablet form together, a tablet in which 30 mg. of crystalline progesterone is incorporated.[5] I have used this preparation in 42 patients with secondary amenorrhea and have attained favorable responses in 65 per cent.[6]

Gonadotropins. Logical use of gonadotropic substances in secondary amenorrhea is limited to that type of dysfunction caused by hypopituitarism. The indication for gonadotropin therapy is the demonstration of a low urinary excretion level of pituitary gonadotropic hormones. Conversely, gonadotropins are contraindicated in amenorrhea caused by ovarian failure, because such patients generally produce an excess of pituitary gonadotropin. It is possible that pituitary gonadotropin of human origin may be available in the future.[7] For the present, however, the proper mode of administration is to use equine and chorionic gonadotropin sequentially. The dose of the former should be 3,000 I.U. intramuscularly daily for 5 successive days, followed by from 1,500 to 3,000 I.U. of chorionic gonadotropin given intramuscularly every other day for 3 doses. When bleeding occurs, the therapy should be repeated once monthly 3 successive times. I prefer to employ low-dosage irradiation in this group of amenorrheal women, because it is easier, more economical, and at least equally effective.

Surgery. The treatment of bilateral polycystic ovaries, particularly when found in association with amenorrhea (Stein-Leventhal syndrome), is surgical. The cystic ovaries are resected lengthwise in wedge fashion, no other therapy being required. Use of this operation, however, should be limited to patients who demonstrate criteria supporting a diagnosis of polycystic ovaries.[8] I have operated on 4 patients of this type, only 1 of whom later conceived despite cure of the amenorrhea in all 4.

Small doses of cortisone have been employed recently in the treatment of amenorrhea caused by polycystic ovaries. The results are not equal to those attained in amenorrheal women having follicular phase (ovarian) defects.[9]

Low-dosage irradiation of the pituitary gland and ovaries. X-ray therapy of the pituitary gland and ovaries is presently the most effective and economical means of regulating menstrual rhythm in secondary amenorrhea. To achieve good results, however, it is imperative to recognize certain contraindications to its use. It appears to be ineffective in a woman previously subjected to unilateral oöphorectomy. It should not be employed prior to the age of 20 or following the age of 35 because of the vagaries of ovarian response during late adolescence and early premenopause; and the possibility of pregnancy must be excluded with certainty prior to the administration of X-rays.

The favorable response of selected amenorrheal women to low-dosage irradiation of the pituitary gland and ovaries is undisputed in recent literature.[10] Interest in such therapy, however, does not rest primarily on its therapeutic efficiency but centers rather on questions of its mode of action, safety, and of the possibility of its delayed effects on posterity. The physiologic basis for the apparent effectiveness of irradiation in secondary amenorrhea, as well as in the associated infertility, is presently inexplicable. None of the manifold theoretical explanations is susceptible of proof. Many investigators, having subjected animals to similar irradiation, have failed to find morphologic changes, in the absence of which it is impossible to establish a cause-and-effect relation.

Proper selection of patients and fixed low-dosage assure the method's immediate safety. Late genetic sequelae have been imputed to low-dosage ovarian irradiation because of certain observations in animals.[11] Recent studies, however, show that experimental data may not be relied upon to predict the occurrence of induced genetic changes in man.[12-14] As a matter of fact, the dose of X-rays administered experimentally to animals has been not only too large in comparison with the quantity administered in low-dosage therapy but has also been of whole-body type. The latter makes it particularly difficult to collate experimental observations and clinical results.[15]

The technic of low-dosage irradiation employed by me is that of Edeiken,[16] in which both pituitary and ovaries are irradiated at each of 3 sittings, 1 week apart. The pituitary gland is irradiated through a lateral portal of 3 by 3 cm., the central ray passing through the midpoint of an imaginary line joining the outer canthus of the eye and the external auditory meatus, alternate sides being used weekly. A single anterior portal of 15 by 15 cm. is employed for ovarian irradiation, the lower border of the field being centered just above the symphysis pubis and no attempt being made to irradiate each ovary separately. The factors employed are 140 kilovolts, 50 cm. focal skin distance, and filtration of 0.25 mm. of copper plus 1.0 mm. of aluminum. A dose of from 80 to 100 r, measured in air, is given each week to each field. The tissue dose reaching the pituitary and ovaries in women of average size is approximately equal, since the pituitary gland is about the same distance from the outer canthus (8 cm.) as the ovaries are from the anterior abdominal wall. It may be calculated from depth-dosage tables that less than half of the air-dosage administered, namely 35 r, is delivered at a depth of 8 cm. Thus, the total dosage received by the pituitary and by the ovaries from 3 treatments approximates 105 r, the former receiving slightly less because of differences in backscattering.

Recent analysis of 90 patients treated by means of low-dosage irradiation because of secondary amenorrhea revealed an incidence of cure, i.e., regularly cyclic menses for at least 1 year, of 71 per cent.[17] The severity of the amenorrhea governs the degree of responsiveness to X-ray therapy, the cure-rate being inversely proportionate to the length of the menstrual interval. It is, therefore, especially valuable to treat oligomenorrhea encountered in barren women by this modality, albeit on an empiric basis. Of the 90 patients alluded to above, 27 conceived within a year of low-dosage irradiation and gave birth to 23 living children.

SUMMARY

Endocrine faults of the female, clinically reflected as disorders of menstruation, occur in 18 per cent of barren patients. Amenorrhea, comprising nearly one half of the group, is worthy of treatment, not only because it evokes sterility through lack of ovulation but also because it is associated with a high rate of pregnancy disaster. The differential diagnosis of amenorrhea includes consideration of several organic diseases, as well as remembrance of the fact that it is possible for a woman to conceive during the course of amenorrhea.

Primary amenorrhea has poor therapeutic prognosis, which may be gauged by the response of the uterus following the administration of large, prolonged doses of estrogen and progesterone.

There is no single or specific therapy of secondary amenorrhea. Presently, it includes correction of abnormal living conditions, prescription of a proper diet, cure of any existing anemia, regulation of disordered thyroid function, administration of ovarian steroids, injection of gonadotropins, employment of ovarian resection, and low-dosage irradiation to the pituitary gland and ovaries. Best results are attained by means of X-ray therapy, the effectiveness of which is presently inexplicable.

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THE REHABILITATION OF ALCOHOLIC PATIENTS IN THE DISTRICT OF COLUMBIA

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THE SERIOUS interest of American scientific investigators in studying alcoholism is less than 20 years old. In 1935 the Laboratory of Applied Physiology at Yale University was laying the groundwork for the present Yale Center of Alcohol Studies. At this time the fellowship of Alcoholics Anonymous was founded. In 1937 The Research Council of Problems on Alcohol began its 12-year life to attempt consolidation of scientifically valid facts relating to alcoholism. By 1940 the *Quarterly Journal of Studies on Alcohol* came into being. In 1944 the formation of the National Committee for Education on Alcoholism by leading American citizens brought into being an effective program of public education against the ignorance and prejudice of most people in so far as alcoholism was concerned. The Salvation Army and the Volunteers of America early in the 1940's expanded their religious service organizations that had long been providing for the needs of 'skid row' habitués. Governmental activity until 1945 was limited to the millions of dollars expended in correctional, punishing activity unrelated to any treatment of the "disease," alcoholism. More recently the therapeutic professions, the American Medical Association in 1951, the American Psychiatric Association in 1948, and the Industrial Medical Association in 1947 have formed committees on alcoholism among their membership. Thirty-eight states and the District of Columbia have now passed laws recognizing alcoholism as a public health problem.[1]

The Department of Public Health of the District of Columbia, under the leadership of Dr. Daniel L. Seckinger, now Director of Public Health, was the first public agency in this country to organize in 1945 a part-time Alcoholic Clinic within the Bureau of Mental Hygiene, with civic-minded citizens 'spark-plugging' the effort. In 1950 the Alcoholic Rehabilitation Program for the District of Columbia, with Dr. Leopold E. Wexberg as director, was activated under Public Law 347, with funds accumulating from liquor license sales fees. The Clinic is located at 23rd and M Streets, N.W. and accepts patients of the District of Columbia for outpatient care who are referred by the Courts or who seek help voluntarily when unable to procure private medical care.

Following the example of the American Medical Association, the President of our Medical Society in 1952, Dr. Wallace M. Yater, appointed a Subcommittee on alcoholism to stimulate interest and coördinate activity in the field of alcoholism within and outside the profession. This Committee recently circulated a questionnaire among the members of the Society and was pleased to notice the interest of the membership on the subject of alcoholism. Four hundred of the questionnaires were returned. A study of these is now under way. The Washington Psychiatric Society, with a membership of nearly 300, has also just organized a Committee on Alcoholism. The Veterans Administration has published an excellent *Technical Bulletin on the Management of Alcoholism*. The Courts, Bar Associations, welfare agencies, religious organizations, management and labor, and the community at large have expressed serious interest in the problems of alcoholism.

The Nature of the Problem

What is alcoholism? Who is an alcoholic? In answering these questions, to be kept in mind is the well-known fact that alcoholism and drunkenness are different phenomena. All alcoholics exhibit drunkenness, but many who get drunk are not alcoholics. The alcoholic is a person who has lost control of the practice of drinking alcoholic beverages to an extent that his interpersonal, family and community relationships become seriously disturbed. The alcoholic drinks because to him an urgency in the form of tension, anxiety, or depression exists which irrationally drives him to alcohol and its excessive use. Most alcoholics hate liquor and hate themselves for succumbing, but they can't stop without help. Selden Bacon[2] views the alcoholic's drinking "as compulsive as the behavior of the pyromaniac, kleptomaniac or the continual hand-washing of a compulsive neurotic." Compulsive drinking is a progressive condition, and the course may be rapid or very slow. The drinking behavior is a symptom of some inner maladjustment which the alcoholic cannot understand and cannot control.

Diagnostically the most frequent personality organization that develops alcoholism is the psychoneurotic. Psychotics, epileptics and the feebleminded may also become alcoholics, and of course this influences the approach to treatment. I know of no specific genetic-dynamic personality make-up for the alcoholic, but we can safely state that at the psychologic level of integration the alcoholic patient's difficulties were seeded before he ever tasted alcohol. Alcoholism, like all personality difficulties, may well be viewed as the resultant of interacting multiple factors, biologic, social, psychologic and cultural, but with the emotional factors playing an important role. This is important to keep in mind because rehabilitation of the alcoholic patient must also take into account multiple factors, medical, neurologic, and psychiatric disorders due to toxic factors, nutritional deficiencies, and psychopathologic developments, as well as the social dislocations at home, at work, and in relation to moral-ethical and cultural values. Often a total deterioration in the value system of the individual is met, and attempts at restoration are indeed most challenging to everyone interested in the patient, as well as to the patient himself.

Concerning the status of physiologic and biochemical knowledge in relation to alcoholism, rational interpretation of present data allows only the statement that, if endocrine malfunction, nutritional deficiencies, or other physiopathologic concomitants are found in alcoholic patients, they are probably secondary complications rather than the cause of the alcohol addiction. These manifestations, however, must be carefully noted because of their importance to current rational therapy. The facts with regard to the pharmacology of alcohol have been well elucidated, and there is essential agreement among all investigators. Alcohol is a depressant. The effects of alcohol on the physiology of man are known to some extent but call for further work, especially in comprehending the mechanism of the hangover effect, the production of fatty liver and liver cirrhosis, the problem of alcohol tolerance, and the nature of "alcoholic epilepsy." The relationship of nutritional deficiencies and endocrine function to excessive drinking needs research without any preconceived notions that a physiologic solution to the problem of the etiology of alcoholism will be found.[1] Research into the Antabuse-alcohol reaction is needed to discover satisfactory means of lessening the reaction and to make safer this useful adjunct to the total treatment of the alcoholic patient.

Treatment

Basic in the current scientific thinking about the chronic alcoholic is that he is a sick man, mentally, physically, and usually both. The medical profession therefore occupies an indispensable and strategic role in any effective program aiming at the rehabilitation of the alcoholic patient. By and large, in the past the medical profession has not been particularly interested in the alcoholic nor sufficiently convinced that alcoholism is, in fact, a medical problem. This latter attitude is most disconcerting and truly indicative of neglect on the part of the medical profession if allowed to continue in any degree. The practitioner of medicine without special training cannot usually be expected to treat the alcohol habit competently, nor would he as a rule wish to attempt the long rehabilitation necessary. But, nevertheless, the part that the medical practitioner can play toward the success or failure of eventual recovery of the alcoholic is often a crucial one. It is the attitude and the advice, but particularly the attitude of the physician whom the alcoholic and his family consult first, that in a great measure determine the course which the alcoholic patient will follow. The understanding and coöperation—or lack of them—by both patient and family will likewise be determined greatly by the initial attitude displayed by the physician.

There are three to five million excessive drinkers in this country. Chronic alcoholics are first excessive drinkers who go to physicians for diagnosis and treatment of other specific illnesses which may or may not be related to chronic alcohol addiction. The attitude of the medical practitioner in handling the alcoholic factor in these situations is therefore strategic from the preventive as well as the rehabilitative aspect. Rehabilitation of the alcoholic patient is a long-term process. Although it is not the average doctor's function to provide this, the doctor has a professional obligation to try as hard as possible to influence favorably the beginning of rehabilitation by appropriate referral to specialists, clinics, and other agencies or organizations interested in this problem. I well recognize that these resources are underdeveloped or nonexistent, considering the scope of the problem. A more active role taken by the doctor in all appraisals of the total problem and his display of understanding and benevolent willingness to assist the alcoholic patient will be followed by an enlightened public opinion. The expansion of medical and psychiatric services in private and public hospitals competently staffed to handle alcoholics can also be expected. Progress in the District of Columbia is already apparent, as I have pointed out. A 40-bed ward at the District of Columbia General Hospital exclusively for nonpsychotic alcoholics, we hope soon will be a reality. Close collaboration with members of Alcoholics Anonymous has prevailed in the planning and will continue in the future operations of this ward and clinic program.

Gaining the patient's coöperation should be regarded as the first part of the therapeutic process. This is often a very challenging problem. Every true sufferer from alcoholism passes through a long period when he is completely resistant to the idea that he is sick and should have help. Often, despite a conscious awareness that aid should be welcomed, the alcoholic resists acknowledging the fact that he is in trouble and should seek advice. Inner conviction that he requires help from others is often lacking.

A primary consideration in the problem of getting the patient to coöperate and to be willing to assume the role of a person who is being helped is that progress toward this highly necessary goal takes time, is difficult, and is at times very discouraging, painful and annoying to the doctor. But there can really be no therapy until the patient has inner conviction that he needs help. The physician must convince the patient, his family, and perhaps his circle of friends of the idea that the patient is suffering from an illness which he can no more handle alone than a diabetic can handle his diabetes. The patient, however, is invited to consider and reconsider that he has an illness for which he needs help. His drinking habits showing loss of control over alcohol being pointed out, the patient can then begin to sense the inevitable downhill course of his condition if drinking continues. This is a softening-up phase of treatment which takes time and repeated hammering away in a gentle, but firm, benevolent fashion. If the patient is pushed, sermonized to, or threatened, resistance is set up, blocking future progress. The patient must come to realize that the use of alcohol for him spells serious trouble and that return to "normal" drinking is a self-deceiving goal. Words alone will not communicate this to the patient if he has failed to learn it from experience. The arousal to his problem-drinking may then have to wait for time to pass and unfortunate experiences repeated until the discovery that he needs help becomes unmistakable and a conviction.

The therapist then takes a more important role in the eyes of the patient, who is aroused to the need for help from someone. Trust in the therapist or fellow Alcoholics Anonymous members may be slow and erratic in developing, and even half-hearted gestures can be discerned. The therapist must continue guiding, not arguing or condemning the patient when a slip occurs, keeping the door open for continual collaboration with the patient. The time will come when the patient will delineate his inner tensions, become sufficiently distressed by his anxieties, and accept wholeheartedly the help from an understanding human being and give genuine coöperation. The problems of living, past and present, can then be worked through as required. Restoration of cultural, moral and physical deteriorations can be accomplished with the help of appropriate agencies and organizations, particularly the fellowship of Alcoholics Anonymous. Psychotherapy of some form, individual or group, is essential if personality understanding and maturity are to be realized. Like any parent substitute the physician must use a judicious mixture of kindness and firmness in his guidance of the alcoholic patient.

The use of Antabuse as an adjunct to treatment of chronic alcoholism is now well established. The drug, when given over a period of days, "sensitizes" the organism so that ingestion of even small amounts of alcohol may lead to serious, fearful, and sometimes life-threatening, bodily reactions of shock-like nature, with prevailing cardiovascular symptoms. Patients are given 0.5 Gm. of Antabuse daily for a period of a week, and a small amount of alcohol (30–60 c.c.) is administered in a test situation. The unpleasant experience should implant in the patient's mind the absolute necessity of refraining from drinking as long as Antabuse is continued in daily doses of 0.25 to 0.5 Gm. The limitations of this drug are: (1) entrusting a patient with a drug that may lead to serious complications, (2) cardiovascular, liver and kidney lesions restricting the use of the drug, and (3) psychotic complications due to toxic action of the drug. It must be borne in mind that the patient can stop taking the drug for a few days and then drink again without untoward reactions. In selected cases, as an adjunct to psychologic approaches, Antabuse has a place in the treatment of chronic alcoholism.

THE ALCOHOLIC REHABILITATION PROGRAM OF THE DISTRICT OF COLUMBIA

This outpatient clinic has received enthusiastic support from the Commissioners, the Director of Public Health, Dr. Daniel L. Seckinger, and the Citizens Advisory Committee on the rehabilitation of alcoholics.

The clinic's functions are listed below:

A multi-pronged, multi-disciplined approach to the rehabilitation of the alcoholic patient is available. Medical, social, psychiatric and psychologic diagnosis and therapy are employed to assist the alcoholic patients to recover.

Medical. Each new patient receives a general physical examination and routine laboratory studies, including an X-ray film of the chest and a blood test. Any organic difficulties are treated or appropriately referred to other community clinics or private physicians. Diseases incidental to alcohol intoxication receive the special attention of the Clinic physician. Patients in need of hospital care are referred to the municipal hospital or to a private institution if the patient can afford the charges. Vitamins, sedation, adrenocortical hormones, etc., are employed when indicated clinically for the patient not requiring hospital care. There is close collaboration between the medical, social service and psychiatric departments in rendering appropriate support to the alcoholic patient seeking help from the Clinic. Antabuse is used in selected cases.

Psychiatric. A diagnostic appraisal of every patient from clinical and genetic-dynamic points of view is carried out by one of the three psychiatrists on the Clinic staff. Therapy is individualized to the patient's needs and ability to collaborate. Supportive or insight-gaining psychotherapy is outlined for the patient as indicated and carried out by a member of the Clinic staff. Various forms of group therapy are available for patients who might have difficulty in an individual therapy situation or as a supplement to individual therapy. All psychotherapy is under the supervision of staff psychiatrists. An *esprit de corps* and close collaboration between the Clinic staff members is maintained by frequent staff conferences to review the Clinic's activities and consider ways of improving the rehabilitation services.

Social service. The social service staff conducts the initial interviewing of all patients applying for treatment at the Clinic. An appraisal of the patient's initial level of need is made and appropriate case-work activity is carried out. Social service is in liaison with other community social agencies that are interested in alcoholics or can be stimulated to such interest. Social workers of the Clinic staff are actively engaged in individual therapy and group therapy activities of the Clinic.

Psychology. Two clinical psychologists are engaged in individual and group psychotherapy. Diagnostic intelligence and projective and aptitude tests are also administered by the clinical psychologists as aids to the treatment of the alcoholic patient. The development of psychodrama as an adjunct to the rehabilitation of alcoholics has been successfully realized. Clinical research projects toward the clarification of alcoholic behavior have been started.

Public Health nurses. The Clinic's nurses assist the physician with the operation of the medical department. The public health nurse conducts interviews with patients requiring medical assistance and referrals to other community clinics. The public health nurse also conducts individual and group psychotherapy as directed by a Clinic psychiatrist.

Occupational therapy. The patient is provided an integrated program of varied group and individual activities with treatment objectives defined by each patient's therapist. Recreational and social activities are also planned. A workshop is available to meet the interests of the patients.

Research. Alcoholism is now seen as the end-result of related and interacting multiple factors, biologic, social, psychologic and cultural, but with the emotional factors playing the most important role. The Clinic program takes particular notice of the latest approaches to the treatment of alcoholism. It is developing new technics of rehabilitation and is searching out heretofore obscure but relevant data pertaining to the cause and treatment of alcoholism. From time to time articles based on our experiences and observations were published in technical journals or presented to the National Conference on Alcoholism.

Education. Community understanding that alcoholism is an illness is essential for the effective planning and operation of an alcoholic rehabilitation program. All the means of disseminating public health information on alcoholism are employed. The District of Columbia Alcoholic Clinic has taken leadership in coöperation with the Columbia Broadcasting System as joint sponsors of a series of 13 television shows on alcoholism, entitled "The Road Back." Lectures, newspaper articles, films, radio programs and training of professional personnel are other avenues for educational activity in the field of alcoholism.

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OVERCONCERN WITH HEALTH*

Somatic and Physiologic Preoccupation: Hypochondriasis

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MOST physicians in clinical medicine are familiar with the patient who is persistently overconcerned about his state of health. The prominent feature in these situations is the discrepancy between the actual amount of pathology or disordered function present and the patient's amount of concern. This discrepancy between the concern felt by the patient and the apparent need for concern from the viewpoint of the examining physician may exist whether somatic pathology is absent, minimal or serious. However, it is more striking when little or no demonstrable pathology is present.

To many physicians this state of affairs is often understandably baffling and frustrating. When one can clearly demonstrate the absence of sufficient pathology to account for the preoccupation of his patient, why can not (sometimes it almost seems will not) the patient accept the reassurance given? When this situation prevails, it is most helpful for the physician to be aware of the existence of the powerful deep-rooted psychologic needs which the patient's preoccupation with his state of health attempts to meet. The physician may be attempting by a direct and rational approach to dissolve psychologic defenses which are not only vital to the patient but which are also out of his conscious awareness. This is an endeavor which is doomed to failure.

The clear and direct statement by the physician to his patient in presenting an accurate appraisal of the state of his physical health is a most important responsibility. Reassurance when there are needless fears of pathology is one of the most useful services of the medical practitioner. Particularly in instances of neurotic overconcern, an objectively presented reassurance as to the absence of organic illness (and without implications suggestive of simulation, imagination, or malingering) can help lay early solid groundwork for the later or eventual redirection of nonconstructive somatic introspection into a constructive study of emotions and emotional conflict.

A failure to appreciate the deep psychologic roots of hypochondriasis will inevitably lead to feelings of helplessness on the part of the physician. The doctor's own self-evaluation hinges to an extent on his professional effectiveness. Accordingly, possible feelings of failure with this kind of patient may lead directly or indirectly into feelings of anxiety, discouragement, frustration or anger, which are not difficult to understand. We can also see how such feelings may be subconsciously "taken out" on the patient. This may take place by a process of displacement of self-critical feelings and the translation of feelings of helplessness into anger. The doctor may expect to be able to change by a purely rational approach the patient's hidden emotional need to focus on somatic matters. He will not have such unrealistic expectations if he has some understanding of the powerful unconscious needs which are present and which force the patient to develop hypochondriacal preoccupations.

Hypochondriasis is the name used to describe the presence of morbid anxiety or overconcern about the state of health. The focus of attention may shift from one organ or system or body region to another, and symptoms may be singular or multiple. Hypochondriasis has been defined as a "persistent overconcern with the state of health," or "obsession with physical functions and body process . . . and the development of various somatic complaints."[1]

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We have thus far learned of the origins of several other diagnostic terms in relation to etiologic concepts of antiquity, e.g., hysteria, wandering of the uterus; melancholia, black bile. Hypochondriasis was believed by the ancients to be due to a disorder of the hypochondrium, the upper lateral region of the abdomen next below the lowest rib, and especially to disorder of the spleen. Modern dynamic psychiatry through the exhaustive study of many cases over the past 60 years has established the origin of pathologic overconcern with the state of health in largely subconscious psychologic processes.

At least one general medical reference dictionary continues to use the word "simulate" in reference to hypochondriacal complaints. I would strongly object to this. In true hypochondriasis the symptoms are not consciously simulated. Hypochondriasis is not malingering. The hypochondriac is the victim of his own unconscious processes, which are out of voluntary control and out of awareness. Consciously and rationally no one would voluntarily choose the constriction in living, the suffering, handicap, sacrifice, and nonconstructive direction of psychic energy which result from the regressive retreat which hypochondriasis dynamically represents, as we shall see.

The trend of current psychiatric thinking is to regard hypochondriasis as a manifestation or symptom-complex seen in many emotional illnesses and not as a diagnostic entity. Among others Freud[2, 3] tended to regard hypochondriasis as one of the three "actual neuroses." He[3] described in 1914 the withdrawal of interest and libido from objects of the outer world to a specific organ selected perhaps because of the ". . . erotogenicity as a property common to all organs."

This paper will comment on the incidence of hypochondriacal complaints and discuss factors in the psychodynamics and pathogenesis of this type of pathologic introspective focusing of interest and attention. The clinical picture will be briefly discussed, together with some special patterns seen, after which will follow a few notes about differential diagnosis and some comments about the medical management, treatment, and indications for referral.

INCIDENCE

Preoccupation with some aspect or other of one's health is quite common. As will be illustrated, hypochondriacal concerns frequently are seen as part of various emotional disorders. We have already seen this illustrated in several types of neurotic illness, as, for example, in neurasthenia as discussed in "The Psychiatric Aspects of Fatigue" in the January issue of the MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA. Hypochondriacal tendencies are not infrequently seen in schizophrenia, involutional melancholia, and certain other depressive reactions, and occasionally in the paranoid states and the psychoses of the senium. Freud[4] regarded paranoid conditions as "almost invariably accompanied" by hypochondriacal symptoms. Sullivan[5] has pointed out the close relation which can exist between social isolation, paranoid states, and schizophrenia. Actually, somatic preoccupation may be present to some extent in any emotional illness. It not uncommonly is present to a mild degree in individuals when emotional problems are not present to a sufficient degree nor with sufficient interference in living to warrant the making of a psychiatric diagnosis.

It is helpful to keep in mind that hypochondriacal preoccupations may be almost normally seen in certain stages of personality development. In the usual course of events this type of regressive retreat is surrendered in favor of more constructive ways of dealing with problems in living.

The person who passes through these stages successfully may be thought of as lacking the strong internal psychologic needs which result in either a perpetuation of this emotionally unhealthy type of response (fixation), or a later resumption of an earlier unhealthy pattern (regression). There are certain conditioning factors which enhance the later prospects for an unconsciously directed retreat into this kind of narcissistic somatic preoccupation.

Hypochondriasis as commonly seen is a medical problem of considerable moment and well deserves consideration from the standpoint of dynamics, management, and other aspects. However, the trend has been away from the use of the term per se as a specific diagnosis. The latest Diagnostic and Statistical Manual of the American Psychiatric Association[6] does not include hypochondriasis as a separate category. Among current writers Alexander[7] is fairly typical in his regard of hypochondriasis as a syndrome which appears in different neurotic and psychotic states. However, cases are still occasionally seen in psychiatric practice in which the absorbing somatic preoccupation is so much the major aspect of the clinical picture that hypochondriasis may occasionally still seem a suitable diagnostic label.

The following case is an example in which existing hypochondriacal tendencies are reactivated and expanded to become the principal feature of an emotional illness following great situational stress.

Case 1. A lieutenant-colonel in the U. S. Marine Corps was hospitalized during World War II because of increasing gastrointestinal complaints. These included poor digestion, flatulence, constipation, abdominal pain, and subjective intolerance to many foods. Following exhaustive physical and laboratory studies, which were essentially negative, his attention remained absorbingly concentrated upon his gastrointestinal functions. He was convinced that some undiscovered organic condition accounted for his symptoms.

Psychiatric examination revealed a robust, athletic-appearing officer who had engaged in a fair amount of immature narcissistic preoccupation most of his life. As one part of this particular arrest or fixation of personality development, he had also always been rather concerned with digestive functions and elimination. This officer had been serving for the preceding 18 months in a combat situation involving maximal emotional stress. Under this constant intolerable pressure the colonel came to focus his interest increasingly upon his gastrointestinal tract and its functioning. This had progressed to the point where he paid detailed attention to the most minute events and variations, keeping exhaustive written records. He had lost his effectiveness as a military officer because a major part of his time, effort and attention had become invested in this nonconstructive, introspective activity. He appeared tense and worried. In talking with him one was quickly impressed with the amount of attention and energy which was directed into these self-absorbing interests.

This officer's response to overwhelming stress had been to redirect his interests and concerns into himself. This constituted an unconscious regressive retreat toward a more dependent position. In view of at least two rather clear earlier periods of somatic preoccupation, one in childhood and a second in adolescence, we might regard this as a return to a somewhat familiar pattern of meeting stress. There were also factors of subjective guilt with the anticipation of punishment. These operated out of awareness (unconsciously). Their effect was intensified through the reactivation of infantile fears of bodily punishment (recurrence of "castration anxiety" from a poorly solved oedipal situation; see "Anxiety, Its Nature and Origins" in the August, 1953 ANNALS). The patient's mother was herself hypochrondriacal. Her overprotectiveness had fostered these trends in her son.

I have reviewed the dispositional surveys of 127 consecutive naval and marine corps officers' cases which were written while I was serving at the National Naval Medical Center in charge of the Officers' Psychiatric Service during the latter part of World War II. In this unselected group of cases, hypochondriasis had seemed the most suitable final diagnosis in 3 cases, 2.3 per cent. However, lest this give a misleading impression, it should be noted that hypochondriacal concerns were present to at least a moderate degree in roughly one third of this group, which constituted a fair diagnostic cross section.

It may contribute to our understanding of the problem of somatic preoccupation to illustrate some fairly typical common instances. In the following example, a child becomes aware of heart action and is concerned.

Case 2. A 7-year-old boy appeared worried and was noted by his parents to have withdrawn from activities with his playmates. He had recently overheard grown-ups describe several dramatic instances of heart attacks and death. He had become impressed with the vital role of his heart and had shortly noticed his own heart palpitation and resulting chest motion upon exercise. He became frightened and withdrew from games involving exercise. His concerns were dissipated following simple explanation and reassurance.

This kind of somatic concern is not uncommon in children and is of course not necessarily pathologic. The important consideration is in the handling of the situation from this point. What reaction is evoked from parents or other significant adults? The possibility of later emotionally unhealthy patterns will be largely determined by the adequacy of handling and the parental attitudes present. The results are cumulative and will include many situations, most of which are less striking than the above. A matter-of-fact approach is important in the dissolution of concern. On the other hand, when this kind of instance in a child arouses the anxiety of an adult, this may have an important place in evolving a pattern of undue concern about health in the child. In other words, if the parent is not concerned, the child is less likely to be concerned.

Not uncommonly adults will develop a hyperacute awareness of a usual physiologic process. The following example was recently discussed with a physician.

Case 3. A 32-year-old mathematician sought advice from his physician about a "thumping in his head" which he noted at night. He was mildly concerned about the possible pathologic significances of what proved to be merely the pulse beat in his ear and which became accentuated when he lay on that particular side. This patient had developed an increased awareness of one of the many sensations which are normally ignored or pass unnoticed.

These 2 cases represent types of preoccupation with some aspect of health which are relatively benign and are not uncommon at one stage or another in living. The amount and degree of hypochondriacal trends can vary widely. The following case is presented to illustrate the more pathologic degree of somatic narcissistic preoccupation which can occur.

Case 4. This patient was a 38-year-old electronics engineer who was referred for psychiatric evaluation because of multiple somatic complaints which were not substantiated on an organic basis during extensive medical study.

At the consultation he described constant frontal headaches, tinnitus, nausea, abdominal cramps, leg pains, frequency of urination, insomnia, nervousness, and lack of energy. He was absorbed in these complaints and could animatedly discuss any one of them in great detail. In fact, these were the only subjects in which he seemed to exhibit much real interest. Psychiatric examination revealed an emotionally impoverished person who was anxious, immature, and worried. His principal defenses against anxiety consisted of his absorbing level of pathologic introspection into his multiple symptoms. His social adjustment was inadequate, and his professional achievements had been in a gradual state of decline over the preceding year. He was concerned about his potency, and his sexual activity was both limited and unsatisfactory.

This patient suffered from a chronic, severe, low level of self-esteem. In attempted compensation he had set impossible goals of achievement for himself. When he had failed increasingly to attain his high levels of professional and personal expectation he had begun a regressive retreat to a narcissistic level of somatic preoccupation. In the briefest summary of the major dynamic considerations involved, this patient had made a dependent retreat in which the anxiety and disappointments were displaced somatically. In addition to his assumption of a more dependent and helpless position through the limiting and handicapping symptoms of his very severe psychologic illness, the resulting suffering also satisfied certain unconscious elements of guilt and punishment.

The citing of these instances is intended to help us understand the wide variety and range of situations in which a hypochondriacal problem may occur. During a recent medical meeting the group of unselected physicians present, which included most of the medical specialties, were asked to anonymously indicate their personal awareness of undue somatic concerns and the estimated frequency of their presence in their clinical experience. Their responses are tabulated as follows:

Undue somatic concerns (preoccupation with the state of health: hypochondriasis):

A. The estimated percentage of my patients in whom this is:

	0-25 %	*25-50* %	*50-75* %	*75-100* %
1. A presenting problem	15	6	1	3
2. A major presenting problem	15	5	1	0
3. The principal presenting problem	13	2	1	0

B. My personal hypochondriacal trends have been:

1. Have never had them.	4
2. Occasional	25
3. Frequent	4
4. Present in early past years	2
5. Present as a medical student	10

As a final note in relation to incidence, we must remember that a vast number of hypochondriacal concerns and problems come relatively infrequently to the legitimate physician's attention, if at all. Without this large group of anxious seekers after health the patent medicine field would not be the lucrative bonanza it remains in consistent year-after-year fashion. Various nostrums and groups of borderline practitioners would also have tougher economic sledding. Another large group of people directs what may be regarded as the equivalent of hypochondriacal preoccupations into avid interests in physical culture, exercises, physical appearance, beauty aids, etc.

Dynamics and Pathogenesis

As indicated earlier, unhealthy introspective preoccupation with body and function represents either defective maturity (fixation), the regression to an earlier narcissistic stage of development, or both. In general, there is a close relation to dependency needs, and in most hypochondriacs the inherent dependency appeal of their complaints is apparent. In certain instances, overconcern with health is so deep-seated and chronic that it appears to almost represent a way of life in itself, constituting in effect a hypochondriacal type of character defense.

At times external stress may bring on hypochondriacal concerns which may then appear to follow precipitating situational factors. Thus, hypochondriasis may follow a serious operation, the serious illness or death of someone close, and a protracted serious or dangerous illness or injury. Traumatic neurosis, the neurosis which may have its onset following minor to major physical injury, is a special combination of situational conversion reaction and hypochondriasis.

In certain instances the onset of hypochondriacal interests following a serious loss may appear to be an equivalent of depression. Herein the somatic preoccupation serves rather comparable dynamic functions to those earlier outlined (MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA, December, 1953). Some psychiatrists might prefer to regard them in turn as secondary psychologic defences elaborated against depression itself. Hypochondriacal concerns frequently accompany depression, varying from mild in degree to the deep somatic delusions which are seen in certain depressions of psychotic depth. In the following case the fairly acute onset of hypochondriacal preoccupation followed the sudden death of the patient's husband in a situation in which the onset of a depression might have occurred.

Case 5. A 68-year-old widow sought medical attention for a number of complaints. These included visual disturbances, weakness, poor concentration, failing memory, insomnia, and various aches and pains. She had been a good driver for many years but now no longer felt capable of driving. She walked with difficulty and sought an arm to lean upon whenever possible. Actually her muscle tonus and strength were good. When she was inadvertently observed or her attention distracted, her infirmities would fall away. At these times her strength and faculties were fine and she would function at the level of someone 20 years younger. Careful medical studies were essentially negative.

The history disclosed a great increase in symptoms (and in her attention to them) following the unexpected death of her husband 3 months earlier. During at least 15 years previously she had become increasingly dependent upon him. Many of her responsibilities including household ones had been shifted to him. His death constituted the sudden removal of an important emotional and supportive crutch. There were strong ambivalent feelings toward the object of her dependence which were repressed from conscious awareness. These were inverted, as in depression, but into somatic areas of concern and preoccupation. (One might compare here the dynamics as outlined in cases 1, 2 and 5 in the earlier article on "Depression" in the December ANNALS.)

The focus of attention in unhealthy but protective and diversionary introspective fashion aided in the concealment and denial of disowned hostile feelings toward the lost object. Consciously she was aware only of positive feelings. Her 'seeking an arm to lean on' was a direct expression of her inner need to lean emotionally. There were clear limitations in living and suffering present. These served simultaneously to gratify unconscious feelings of guilt and to provide a dependency appeal for sympathy, pity, concern, forgiveness, and a replacement for the lost object of dependency.

Judicious medical handling in a kindly but matter-of-fact way, in addition to a high degree of intuitive understanding and limited, clearly temporary support by several family members, contributed greatly to the gradual improvement which took place. She was able to surrender the major part of the hypochondriacal preoccupation which had developed. The danger of a chronic invalidism was averted. This patient was gradually able to resume more healthy interests and responsibilities, including some of those earlier handed over to her husband.

The physician may find it difficult to maintain an objective, patient, and unbiased view in the presence of persistent hypochondriacal preoccupation, and what can be another disturbing element, the accompanying dependency demands of the patient. This, in addition to his relative professional helplessness, and the sometimes rather apparent factors of secondary gain, has resulted in the term "hypochondriac" sometimes acquiring an unfortunate position as a medical term of opprobrium, scorn, or castigation. One aid in avoiding this pitfall to being of real help to the victim of hypochondriacal preoccupation is for the physician to constantly ask himself, "What purpose do these complaints serve?"; "Why must the patient invest so much effort in such a nonconstructive direction?"; "What might be some possibilities as to the real source of his anxieties?"; "What is his real worry?"

Essentially, an emotional concern with the state of health is a defense against anxiety. This particular pattern of response often has its roots in the very early parent-child relationship. As referred to earlier, Freud[2] distinguished "three pure forms of actual neurosis: neurasthenia, anxiety-neurosis and hypochondria." Freud[5] also early noted (in 1896) the relation between shame and self-reproach for a disapproved sexual deed and hypochondriacal anxiety as a guilty fear of bodily injury. This can develop further in psychopathologic sequence into phobic manifestations as "fear of punishment— for the lapse" and on into delusional areas. Today this concept of superego (conscience)-disapproved sexual acts as an etiologic basis, while still applicable, might be broadened to include the translation of the uncomfortable feelings of various types of emotional conflict into anxiety and on into hypochondriacal preoccupation as a defense. This pattern in patients with a hypochondriacal predisposition could potentially arise as a consequence to almost any conflict-producing action, feeling, or thought.

I have found it convenient to regard the unconsciously sought aims of hypochondriacal concerns as divided into what we might again refer to as the "primary" and "secondary" gains of the illness. As in the conversion reactions, depression and emotional fatigue, the division is an arbitrary one, made for convenience in study and teaching largely on the basis of a presumed level of unconsciousness (relative inaccessibility to conscious awareness).

The "primary gain" of the regressive narcissistic preoccupation with soma is related to the concealment and denial of disowned needs and drives. The somatic concerns are aimed at reenforcing repression of the disowned impulses, awareness of which would produce anxiety. Thereby we may, in condensed fashion, think of hypochondriacal symptoms as representing a channeling of anxiety into substitutive (and less troubling) bodily areas. The areas selected for attention and concern are not picked by chance, but in turn are undoubtedly selected unconsciously with symbolic meanings. These, however, may be most elusive.

The disowned needs, wishes and drives are largely made up of aggressive and hostile or sexual ones. Preoccupation with somatic matters actually serves to keep the attention directed selectively away from these dangerous areas which are then less likely to come into conscious awareness. This redirection also occupies energy and effort which cannot then be available for action in response to the discarded wishes (or for introspection). In regard to the latter, it is not too surprising during the course of investigative psychotherapy to see patients (1) develop a new absorbing symptom or body concern, or a rash of them, or (2) have a recurrence of somatic difficulties which had been relatively dormant. This should be a signal flag to the therapist that something has threatened the defenses of repression or has come "too close for comfort." Although this may arise solely on the basis of external factors, it may also indicate that collaborative treatment is coming closer to something psychologically significant which threatens existing, well-established defenses. This signal may be compared to the guiding cry of "you're getting warm" and "warmer" or "colder" given by the onlooker to the searcher in the childhood games of hunting a hidden object.

As an example of this reaction, I recall the case of a clothes designer under intensive treatment who almost regularly developed varied troublesome symptoms as study approached areas of particular conflict. At the same time he resented the negative findings and the lack of concern by examining physicians,* particularly in the early months of his analysis. On one occasion he said with some vehemence, while suffering with chest pain which he associated with cancer of the lung, "It would serve the doctors right if I went on and died, even if just to prove how wrong they are!" (partly, at least he really means—"in not giving me the serious concern which I merit and the attention and retreat I am seeking in this nonconstructive and immature fashion"). Among the destructive effects of this type of symptom development is of course its interference with therapy, as a diversion and as a resistance.

Careful judgment is required to know how far to press the search and when to ease off. The arousal of anxiety during psychoanalytic treatment, however, is inevitable. This sort of somatic response in the patient who expresses his anxiety thereby can help us understand the need for the caution which should apply in the evaluation of those possible candidates for analytic therapy who have had such things as serious hemorrhages for peptic ulcers, dangerously high blood pressure, or very acute asthmatic attacks. The patient must have sufficient physical reserve remaining to tolerate possible exacerbations which might take place in response to anxiety mobilized during the course of his treatment. The referring physician, understanding this, will be better able to coöperate in the evaluation of such patients for referral and in giving such medical assistance as may be indicated during the course of therapy.

The "secondary gains" refer largely to the possible effects upon other people, which are largely unconsciously sought through the symptoms. These include such things as the satisfaction of dependency needs, the regressive return to a more passive, less mature level, the avoidance of responsibility, the seeking of sympathy, concern and pity, and the escape from an intolerable situation.

It is the presence of these secondary gains which has so often in the past aroused the physician's antagonism. They may be painfully transparent and irritating to an objective observer. It may appear that the patient cannot help but be fully aware of them and that his apparent bland ignoring or denial of such blatantly sought goals is a calculated affront to the intelligence of the observer. It is this that has helped the term hypochondriac sometimes to acquire an accusatory and derogatory connotation. The real mechanism of secondary gain is not available to conscious awareness and does not result from conscious planning and scheming. While the doctor may clearly see the gain and intent, the patient remains largely blind and will with justification vigorously and angrily deny an accusation as to his consciously attempting the secondary goals sometimes so obvious to others. When there is conscious planning present and simulation, the patient is malingering and not suffering from hypochondriacal concerns.

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* Actually his resentment is in hidden fashion in response to (1) the physician's refusal to redirect his medical interests also into these less threatening somatic areas, and (2) the physician's failure to respond as wished to the dependency appeal inherent in his complaints.

In passing it might be well to note that true malingering is rare. Many cases of conversion, functional disturbances, hypochondriacal concerns, and other emotional difficulties are sometimes so regarded. In these circumstances a grievous medical error may well be committed. Such an error destroys rapport and confidence and may long delay or even end the potential help available via constructive psychotherapy. I would like also to point out that a favorable response to a placebo by no means necessarily proves the existence of malingering or simulation.

In the traumatic or occupational neuroses a false evaluation of malingering may also be made. Although this is not infrequent, there is also another trap for the physician which we shall see illustrated further when these reactions are considered. I refer here to the physician being "taken in" by the situation so that he comes to regard the initiating trauma (as does the patient) as the sole basis for all symptoms. This is potentially of great injury to his patient, based as it often is upon sincere conviction, protectiveness, and perhaps identification. The damaging result is to afford external objective support to the patient's unconscious factors of secondary gain, regressive helplessness, dependency seeking, and compensation. Any possible existing mild interest by a patient in securing psychotherapeutic assistance in these situations is most unlikely to survive if his physician unwittingly supports the neurotic dependency striving.

To lead to malingering, a person must have desperate internal needs, a great lack of self-respect, and an immature and maladjusted personality. Malingering in itself becomes an evidence of serious emotional difficulty. Unfortunately, the very nature of the emotional problems of the malingerer makes it unlikely that much interest can be secured in any real collaborative effort at constructive introspective study. In any event, as Masserman[9] comments, "too much time and energy should not be wasted in hair-splitting as to which symptoms are 'consciously' determined and therefore classifiable as 'malingering' and which are 'unconsciously' determined and thereby 'neurotic'." This is particularly true from the standpoint of treatment in most cases of neuroses. There is little justification either for spending much time or effort in a differentiation where the purpose is really one of moral judgment. The practical value of such determinations lies primarily in early assessment of suitability for possible treatment. Unconscious mechanisms indicate a neurosis with a good treatment potential; conscious simulation primarily indicates character and behavior disorders with usually a poor treatment potential. In military service the distinction may be very important as to the disposition of the case.

Hypochondriacal concerns are essentially a regressive phenomenon. The symptoms attempt an unconscious defense against the anxiety of threatened depressions or loss of control, as noted earlier. This regression is toward a narcissistic and auto-erotic level of interest. There are also implications as regards guilt and punishment, since the hypochondriac suffers. This may represent suffering in retribution for unacceptable sexual or aggressive wishes. Silverberg[10] noted that hypochondriacal fears may relate to anticipated punishment from oedipal wishes.

Fenichel[11] pointed out that "Among the impulses that are withdrawn from object to organ representations in hypochondriasis, the hostile and sadistic impulses appear to play a particularly pronounced role. The original hostile attitude toward an object is turned against the ego, and hypochondriasis may serve as a gratification of guilt feelings." This, in addition to other points, is illustrated in the following case.

Case 6. A 27-year-old housewife sought treatment for recurring attacks of anxiety which were manifested chiefly by her intense preoccupation with the fear of some serious bodily disorder. These states had occurred in episodic fashion all her life. The earliest she could recall dated back to age 5 when she had suffered a "heart attack." Later, such attacks were repeated and alternated with acute fears of poliomyelitis. Still more recently there were episodic attacks of cancerophobia. Her emotional illness was basically an obsessional disorder in which hypochondriacal preoccupations were the outstanding feature.

In her position in the early family, the patient had assumed the role of the docile compliant child to an unusual degree. This was in contrast to her older sister who was considered more attractive, and who was an object of constant concern to the parents, both from the standpoint of illnesses and injuries and from deviant problem behavior.

In the course of analytic work it became apparent that the hypochondriacal attacks occurred whenever strong wish tendencies or aggressive-hostile feelings were being forced into awareness. Since her very character structure had been developed to ward off the recognition of such aspects of the self, any event of life development that provoked such feelings came to be experienced as a dread threat. The hypochondriacal attacks that followed acted to turn the threatening feelings away from the outward object or person and inwardly toward the self. At the same time this represented a regressive and narcissistic retreat into the self, and in addition carried out self-punishment as an expression of guilt feelings, since it was the patient who suffered more than anyone else.

Gradually it became possible for the patient to turn her attention, whenever the attacks occurred, externally from her symptoms and somatic fears into what she was really feeling toward those close to her, and what was actually transpiring in her interpersonal relationships. Her self-understanding increased as she found that she increasingly dared to allow herself awareness of her real feelings. As she became able to accept more and more the presence of negative and hostile feelings within herself, the episodic hypochondriacal preoccupations decreased in frequency and severity.

In certain cases we can clearly trace the development of undue somatic preoccupation and concern to emotionally unhealthy parental influences. In simplified and highly abbreviated form, this was discussed and illustrated in case 3 in "The Psychiatric Aspects of Fatigue."[12] Parental overconcern with personal health and function is a strong developmental factor in later similar attitudes in the child. In this development the mental mechanisms of identification and introjection play an important role. The development of the superego (wherein resides the "internalized parent") is accompanied by the taking over by the child of many parental attitudes. Kanner[13] regards the "imitation of observed adult patterns" as a prominent source of hypochondriacal attitudes in children and cites examples of the relationship of parental overconcern to concern of the child. In certain instances pathologic overconcern with the health and safety of a child may represent a reaction formation against the unconscious hostile and aggressive impulses by the parent and a denial of them.

A pathologic overconcern with health serves as a means for the avoidance of disturbing and painful emotions or emotional problems. In some instances parents may have found it "easier and more comfortable" to focus their attention on the "physical" disorders of their child in lieu of facing the real difficulties, the emotional problems that exist in the family, perhaps out of awareness. It may serve as an unconscious substitute for love and affection.

Some of the various foregoing points in the pathogenesis of hypochondriasis are illustrated in the following case:

Case 7. A single 35-year-old assistant editor for a publishing firm was originally referred for psychiatric evaluation and possible treatment because of problems in her personal relationships and increasing overconcern with health matters. History disclosed an increasing retreat into somatic preoccupation over the preceding 2 years. A person of considerable ability and initiative, she had worked her way from a clerical job to work of a professional level in which she had performed with great competence. There were multiple complaints present without organic findings. Treatment was clearly indicated but was accepted by the patient with considerable difficulty. One stated and a second implied accusation of malingering during the course of many visits to various physicians had tended to promote a great deal of distrust and lack of confidence in medical help. This had undoubtedly both impeded and delayed her acceptance of the vitally needed psychotherapeutic study of her areas of emotional conflict.

During the course of early psychoanalytic study an important situational initiating factor was discovered to have been the breaking off of an 8-year love affair when the conclusion finally became unavoidable that there was no prospect of a satisfactory marriage. The patient had unduly concentrated her attention and interests in this one relationship. Her father had died when she was 12, and unconscious factors of seeking a replacement had entered into the unrealistic degree of dependence on the relationship and her resulting severe loss. Her response had been regression and retreat into narcissistic concerns. During the course of a prolonged but successful analysis the dynamics gradually became clear. The highlights of these in highly summarized form reveal some of the psychologic roots of her illness.

The primary gains related to the denial and control of her deeply repressed murderous rage toward the object of her disappointments. Part of the defense against anxiety was in the channeling of her interest and attention away from conflicts relating to both rejected sexual impulses and activity and the forbidden aggressive drives. Since these threatened to be overwhelming if admitted to conscious awareness, the somatic preoccupation was a desperate attempt to reënforce their repression from conscious awareness. At the same time, energy potentially available for carrying out prohibited activities was dissipated. Further, the incapacitation and suffering served to satisfy the demands of a harsh superego for punishment in both areas.

Factors of secondary gain in this case largely related to the regressive retreat toward a more dependent and child-like level of adjustment and toward a less active and less responsible relative position with her family. There were elements of attention and sympathy-seeking as a neurotically sought replacement for love and affection. During the course of therapy several other fairly typical features were illustrated. There was ample evidence of unwitting contributions from parents in the form of oversolicitude which had largely replaced genuine affection. On a number of occasions when therapeutic study approached areas of rejected and disapproved drives new symptoms developed. Treatment results were very good in this case and were facilitated by the patient's intelligence, coöperation and the early excellent rapport established with the therapist.

For many persons it is easier to face the prospect of organic disease as a more tangible problem than the hidden and painful areas of emotional conflict. This is occasionally rather dramatically illustrated as in the following case in which the patient welcomed the discovery of diabetes.

Case 8.[14] A 41-year-old professional writer sought psychoanalytic treatment because of serious areas of adjustment difficulty with her husband and children and because of associated symptoms of headaches, nervousness, insomnia and poor digestion. Irritability and depression accompanied menstruation. All of these manifestations had increasingly interfered with her professional output.

Although the patient had voluntarily sought help and was sincere in her analytic work, the going was very tough. Progress was greatly hampered by her protective avoidance of significant areas and a considerable personality rigidity. She persistently hoped for an organic explanation of her troubles, despite the negative findings of repeated medical studies.

One day a medical examination disclosed incipient diabetes. Although she knew full well the implication of severe diabetes (which she believed her case to be), she became relieved and literally gleeful upon receipt of the news. The discovery of the diabetes at least temporarily provided her with something less painful, something less difficult to cope with, something more tangible to her than the repressed and painful emotional conflicts primarily responsible for her troubles.

Thus, in our study of the dynamics and the pathogenesis of hypochondriasis we have seen how somatic and physiologic overconcern is one unhealthy attempted way of handling anxiety. Hypochondriacal symptoms are a means of narcissistic regressive retreat. This pattern of response has its origins in early childhood and may be unconsciously fostered in the parent-child relationship. By the focusing of attention

(*Continued on page 132*)

President's Page

MEDICAL BUREAU EXPANDS

Last October 9 at 6 A.M., the installation crew of the C & P Telephone Company "cut over" from the old 4-position switchboard to an entirely new 7-position board. December 2 marked the 13th Anniversary of the Bureau and physicians who visited it during the "open house" December 16 to 18 were amazed at its growth.

The Bureau began operation December 2, 1940, with 115 subscribers. On December 31, 1953, the number of subscribers had increased to 759. Total Bureau load in 1953 was 446,018 calls in and out, averaging 1222 per day. Greatest load in one day in 1953 was February 1, 2436 calls. This service, rendered by a total of 26 operators, cost over $59,000 in 1953, entirely met from subscribers' fees at no cost to the Medical Society. Salaries of operators in 1954 will be $50,000. In addition to the above the operators carry the enormous telephone load of the Society's offices with their 14 extensions.

The service rendered the public and physicians by our Medical Bureau has gained nation-wide attention as the finest operation of its kind, and its ability to furnish a physician quickly in an emergency has received widespread approbation.

Herbert P. Ramsey

Editorials

HEART MONTH

Each year the month of February, with St. Valentine's Day as its fitting symbol, is dedicated to the Heart Fund Drive. During this period the public is actively solicited for funds to help combat some of the evil effects of heart and blood vessel diseases. The 1954 Heart Fund Drive is now in progress, under the slogan, "Help Your Heart Fund Help Your Heart."

No group appreciates better than we physicians do the tremendous importance of the cardiovascular diseases in causing morbidity and mortality among our people of all ages. Collectively these diseases represent, without question, the major health problem of our time. Regardless of our individual medical interests, whether we function as specialists in obstetrics, pediatrics, internal medicine, or surgery, etc., or serve with equal importance as general practitioners and family medical advisors, each of us in our professional activities regularly encounters diagnostic and therapeutic problems in the cardiovascular sphere. As physicians we have a particular responsibility continually to promote advances in medical care. Recent years have brought remarkable progress in this respect in the cardiovascular field aided and abetted by support from Heart Fund Drives and from many other sources. It is especially appropriate, therefore, that we physicians contribute our active interest, our energies, and our own dollars to this worthy cause.

The American Heart Association has served long and honorably the role of promoting, at the national level, a greater knowledge of, and better medical care in the cardiovascular diseases. This it has done through considered programs of research, education, and recommended Community Services. Your own Washington Heart Association has been for many years a direct affiliate of the national organization and is committed to accomplishing these same objectives in the metropolitan area of the District of Columbia. The Scientific Council of the Washington Heart Association cordially welcomes all physicians in this locality, whatever their primary medical interests, into its membership, that they may aid in these endeavors.

By means of public contributions to the Heart Fund Drive, aided by the interest and energies of numerous physicians and lay individuals, the Washington Heart Association promotes and provides direct financial support for many ancillary services to the medical profession in the cardiovascular field, on the basis of "the doctor prescribes, the Heart Association provides." These services, briefly summarized, include:

RESEARCH—national and local
EDUCATION—for lay public and medical profession
INFORMATION—general and specific
COMMUNITY SERVICES—
  Camps for Cardiac Children
  A Children's Magazine, *The Happy Hearts Club*
  Cardiac Clinics: Equipment and personnel
  Rehabilitation Services:
    For the Homebound
    For Occupational Therapy Workshop
    For Employment
    For the Cardiac Housewife.

Utilize these services. Contribute to their im-

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia.

provement. Also contribute some of your dollars to this worthy, many-sided effort to improve total medical care in the cardiovascular diseases.

Help Your Heart Fund Help Your Heart!

CLAYTON B. ETHRIDGE, M.D.
President, Washington Heart Association

RED CROSS FOOD AND NUTRITION SERVICE

The District of Columbia Chapter of the American Red Cross has as a part of its health education service a food and nutrition service. The program of nutrition activities is planned and carried out by a volunteer working committee whose chairman and several other members are qualified professional nutritionists. A food and nutrition Director is employed as an advisor to the committee and is responsible for administering and carrying out the activities with its help.

The unique volunteer program and the many coöperative relationships with other community groups enable the Red Cross to pioneer and demonstrate programs with small cost. Because of the current widespread interest in weight control as a major public health problem, the Community Nutrition Committee of the District of Columbia Dietetic Association is interested in conducting a series of classes on weight control in the community. Members of this association have arranged to work jointly with the Food and Nutrition Service of the Red Cross Chapter, utilizing its facilities and organized nutrition program in carrying out the demonstration. This project would be a voluntary community service. One purpose of the course is to help the individual who is living on a limited income to meet the requirements of his diet in relationship to current food costs in our city. Plans are under way for initiating the project in early February with a pilot course to be carried once weekly for a 10-week period. The course will be held at the new Chapter building, 2025 E Street, N.W. This project plan has been presented to the Committee on Public Health of the District of Columbia Medical Society. It was endorsed by that committee and subsequently approved in principle by the Executive Board.

Candidates for the class must be referred by dispensary or private physician. It has been planned that about 20 patients be selected for the original course. Referral cards are to be supplied, and the referring physician will be asked to state the condition of the patient, the rate at which he wishes him to lose, and the number of calories his daily diet should contain. In the case of diabetics, the doctor will be asked to state the patient's basic prescription in terms of protein, fat and carbohydrate.

The course content will be based on normal nutrition with emphasis on low calories within the adequate diet. It will be presented in a simple, understandable way.

Many of the services carried on in the Red Cross either provide food or include food and nutrition education as a part of its total health education program.

A few examples of the interrelationships of Food and Nutrition Service with other Red Cross services will illustrate the point of a sound food and nutrition education program. The Red Cross provides for technical guidance from experienced food and nutrition workers whose responsibility it is to train volunteers in mass feeding for the Disaster Committee and the Canteen Service; to prepare and interpret the family budget guides which its Home Service staff uses in determining financial allowances for food, shelter and clothing; to assist with the nutrition education phases of the Mother and Baby Care and Home Nursing courses given by Nursing Service; and to give guidance to teachers on the coördination of nutrition education with the total school program through Junior Red Cross.

Many of the nutrition education aids and materials regularly prepared for Chapter use are made available to other community agencies. Consultant services and nutrition instruction are also requested by many agencies and groups in the Greater Washington Area.

The Nutrition Service of Red Cross is happy to participate in this important project on weight control as a service to both the community and the medical profession.

Henry A. Grennan, M.D.
Chairman, Home Service Committee,
American Red Cross District of
Columbia Chapter

ADMIRAL BOONE REPLIES TO CRITICS

To the Editor:

On pages 674 and 675 of your December issue, there appears an article under the title of "Nonservice-connected Disabilities and the VA," written by Dr. Oscar B. Hunter, Jr., Chairman, Veterans Affairs Committee, National Medical Veterans Society.

Dr. Hunter's basic position is that the medical care provided veterans by the people of the United States is something new. He takes the position that under the honorable robe of gratitude of thankful people, socializers are attempting to delude those who served in the armed forces with this new concept.

There is nothing new in the medical and hospital program the people provide for their veterans. It has existed since World War I.

The veterans medical program exists by authority of Public Law No. 2, enacted by the 73rd Congress, and various amendments and Executive Orders, dating back to 1933. There has been no new development changing the medical program for veterans since that date. An attempt to present this as a new program and to wash out all memory of the past can only serve to delude the public and to confuse issues.

Dr. Hunter points with fear and trepidation to the fact that the impact of World War II has caused an increase in the number of beds operated by the Veterans Administration from 81,000 to 120,000. (This figure is incorrect, it is nearer 114,000.) He fails to point out that in the same period the number of veterans increased from approximately 4,000,000 to approximately 20,000,000. In other words, the veteran population has increased approximately five times, while the number of beds has increased by little more than one half.

More than one half the total number of beds are devoted to the care of neuropsychiatric patients, a group which the Nation is totally unprepared to care for through state, community or private facilities. Were it not for the Veterans Administration, they would be roaming the streets.

Dr. Hunter points with anguish to the 20,000,000 veterans in civil life, foreseeing the need for an ever-expanding Veterans Administration hospital program to care for them.

There has never been a proposal that the Veterans Administration should provide beds to care for all veterans. There are about enough beds in operation to care for not more than ½ of 1 per cent of the veteran population at any given time; and, not more than 2½ per cent of the veteran population is cared for in Veterans Administration hospitals in any given calendar year.

In pointing out the socializers who will bring about the catastrophe he foresees, Dr. Hunter identifies them as the service organizations—a group which, he says, are "controlled by a handful of service officers who in many instances are employed by the Veterans Administration and act as the only tax-supported lobby in the country."

The Veterans Administration employees come under the Civil Service rules and regulations. The Hatch Act specifically prohibits any such persons from participating in politics and makes such participation punishable by dismissal. If Dr. Hunter knows of any personnel who are violating this law, he, as a citizen, has an obligation to make this known so that such law violators will not be continued as a "tax-supported lobby."

Dr. Hunter charges, "Actually the veteran is not entitled to free hospitalization in the Veterans Administration program unless he has a service-connected disability, but by law, where existing facilities are available, certain priority is given for hospitalization for nonservice-connected disabilities."

Frankly, I don't know what he is talking about when he says a priority is given for nonservice-connected disabilities if by priority he means that they come first. They do not and never have. As for entitlement, no veteran is entitled to any consideration, except as it is given by law. The service-connected veteran and the nonservice-connected veteran are each entitled to hospitalization and other benefits as they are established by law and there is no other entitlement.

When the doctor says that the veteran has been frequently told that he need not be concerned as to the statement as to his inability to pay, he completely ignores the form which the veteran must sign when applying for hospitalization. There is plainly printed on the form the following: "WARNING.—If you knowingly make a false statement of any material fact in or in connection with this application, you are subject to possible forfeiture of veterans' benefits, and prosecution in a United States Court." This clearly puts the veteran on record as knowing the importance of the statement he signs.

Dr. Hunter says that veterans are "pushed by service officers of service organizations to accept Veterans Administration hospital care when many of them if left alone would prefer to stay at home."

Dr. Hunter completely ignores the fact that more than 25 per cent of the general medical and surgical patients treated in Veterans Administration hospitals are referred to the Veterans Administration by private physicians and hospitals after their funds are exhausted. If the Veterans Administration didn't take care of them, who would?

Dr. Hunter says that all communities "have felt the depletion of their trained personnel. Doctors, nurses, technicians, have flocked to the Veterans Administration hospitals for better salaries, leaving community hospitals. . . ."

The highest that any doctor can receive in the Veterans Administration, except for several statutorily provided, is $12,800 a year. The most recent figures I have seen on salaries for doctors generally appeared in *Medical Economics*. It was stated there that the average income of the general practitioner in private practice was something more than $14,000, while specialists averaged slightly more than $17,000. In view of this, it is a little difficult to see why they would flock to the Veterans Administration if they are interested in making money.

As for the nurses, Veterans Administration salaries compare favorably with those generally paid in the United States. In a few areas, the Veterans Administration salaries are lower than those paid locally. In other areas they are higher. It must be borne in mind that Veterans Administration nurses do not enjoy the fringe benefits which are provided hospital nurses in private institutions and which tend to more than equalize pay schedules.

As for technicians, the Veterans Administration is probably the biggest training ground for technicians in the country and does more than its share to provide workers in this category for others.

Rather than being attracted by money, the Veterans Administration believes that doctors are attracted by the progressive spirit which permeates its hospitals and clinics, and which is constantly fostered by the country's leading medical and dental colleges that have joined forces with the Veterans Administration and share the privilege of meeting the medical needs of our veterans. This close cooperation between the Nation's foremost universities and medical schools and the Veterans Administration is evidence of the fine medical achievements that can be brought about by Government and private medicine working together. It is one of the proudest accomplishments of today's medicine.

In my opinion, this unity of interest clearly points away from socialism and toward better medicine for all mankind.

In view of the fact that the MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA saw fit to publish Dr. Hunter's article, it is requested that this letter be published in the ANNALS so that its readers can be factually informed. I know you, as Editor and being a very high-minded person, would wish to make the facts available to them.

Very sincerely,
Vice Admiral J. T. BOONE, M.C., U.S.N. (Ret.)
Chief, Medical Director, Veterans Administration

In and Out of Focus

BY THE OBSERVER

What Medical Students Think

Last September your Observer accepted an invitation to speak to the senior medical students of the University of Arkansas. Subsequently, he received an invitation to give a series of lectures to the seniors at Georgetown University School of Medicine. In considering what he might talk about to the former group and on his first appearance at Georgetown, he hit upon the idea of probing the minds of students to ascertain what was uppermost in their minds about problems which would face them upon entering practice and what thoughts they had about the future of medicine.

The more your Observer thought about the idea, the better it seemed to him. He finally communicated with the deans of the respective medical schools, inquiring if they would be willing to coöperate by requesting the completion and return of questionnaires which your Observer had prepared. The request was granted, and, thereupon, a canvass of senior medical students was made. While there were some variations in the questions asked of the students in each school, in general the questionnaires were similar.

Because of limitation of space, it will not be possible to analyze in detail the replies received; an analysis will be incorporated in an article to be published in the near future. A few highlights and some of the more significant statements by students should, however, be of interest.

First of all, approximately 50 per cent of those to whom questionnaires were sent returned them. Interestingly, 97.5 per cent of those who replied at the University of Arkansas, and 94 per cent at Georgetown planned to enter private practice.

Your Observer did not inquire at the University of Arkansas how many intended to specialize, but at Georgetown 32 or 59 per cent of the 54 who had decided to enter private practice said this was their plan, while 19 or 35 per cent said they expected to enter general practice. The fact that a larger percentage at the University of Arkansas stated they proposed to establish themselves in rural communities should occasion no surprise.

The problems uppermost in the minds of the senior medical students at both institutions were nearly identical. As most contemplated private practice, their questions can be summed up as follows: where to locate; how to establish a practice; how to finance it at the beginning; whether it would be desirable to enter partnership; and, finally, how to separate one's family from professional existence.

Particularly interesting were the students' views about the future of medical practice. Especially encouraging were repeated statements that they had resolved to adhere to the highest ideals. The following is a statement of a University of Arkansas student:

> "I believe that the doctor should develop more genuine interest in his patients, regardless of race or economic level. I also believe that doctors should not charge excessive prices, which they are doing in some localities. If the cost of medical service continues to rise, I believe the public will seek cheaper service regardless of the quality, leading to socialized medicine."

Quite a number anticipated great changes in medical practice. Several thought it would be in the direction of group practice. Here are samples of their views:

> "Group Medical Practice will become increasingly more popular among physicians."

> "Group practice will eventually be the only good way to practice good medicine."

> "I believe in group practice in small clinic-hospitals

in rural communities, and group practice in small clinics with available publicly-owned hospitals of 75–150 beds in 5,000 to 20,000 communities."

"I am in favor of group practice among men who are adequate enough to trust one another and to do honest work."

While a large number proposed to enter general practice, a majority were concerned about the future in this field. Said one:

"Having gone into medicine with the view of becoming a general practitioner, I have begun to wonder if the role of the general practitioner in the future is going to be less. I plan to practice in a town of about 10,000 with a hospital of 80 beds. At present, there are 4 doctors in the community—none of whom are Board-certified or Board-eligible. Two of the men do surgery, in addition to general practice.

"My original plan included a general practice residency for 3 years with 1½ to 2 years devoted to surgery. However, I have been told by many hospitals that GP residencies do not include surgical training, as all surgery is done by Board-certified men. I have also been told that, more and more, specialty training is limiting the work of the general practitioner both in actual practice and by means of medical politics. One of the solutions offered is to become Board-eligible in a field and then do general practice. I had thought that the pendulum had swung away from specialization—toward the general practitioner—but it would seem that it has just begun."

Another said:

"I feel that specialization is being carried to extremes so that the general practitioner is being allowed to do less and less. It makes one wonder just how the GP will fit into the picture in 15 to 20 years and whether he won't be just a clearing house to refer the patient to the appropriate specialist. I feel that the specialist should serve as a source of consultation to the general practitioner and that the GP should continue to handle the cases except in the fields of surgery and complicated obstetrics. I also feel that some settlement should be arrived at whereby the general practitioner who goes out in the night to see a patient with an acute abdomen and works this patient up and then turns him over to a surgeon should be properly rewarded financially for his efforts without the accusation of 'fee-splitting' being thrown at him."

Some pessimism was expressed, the following being an example:

"Medical care of the chronically ill and aged will become the number one medical problem of our society. This terrific problem brought upon us by the profession's ideal of prolonging life, which is now possible as never before, will probably only be met by the 'Welfare State,' which will provide hospitals and 'recovery homes,' employ the many nurses needed, and pay for the services of the geriatricians and physical therapists who will be required. By this time almost all of the acute diseases will be conquered, most of the present surgical diseases will either be treated by drugs or transplantation procedures; and the emphasis will be on preventive medicine. Private medicine cannot help but give way more and more to Public Health and Welfare medicine as the present goal of prolonging life is more nearly reached."

While optimism was not too much in evidence, the students displayed no lack of confidence in their ability to meet demands which might be made upon them. One student wrote:

"I think medical practice of the future will be superior, due to the rapid advancement of research and better training of physicians. This will prompt more men to 'stay on the ball,' or find other fields of interest."

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Fine Print Spurs Probes

In the past year or so, television and radio audiences have been getting an ear- and eye-full of health insurance sales talk. Highly optimistic commercials would lead to the belief that medical costs are no longer a problem; that complete protection is available to everyone at a cost within their means. Of course, nothing could be further from the truth.

In the past year or two, your Observer has been a more or less patient listener to many of these radio commercials—he still does not have a television set. As a result he has become increasingly certain that sooner or later the commercial insurance companies guilty of extravagant claims would be the target of an investigation and, in this event, that the voluntary health insurance movement would suffer. Troubled, he discussed this matter some months ago with a public official whom he thought should be interested in the matter. He received little encouragement and was told that if he would bring in evidence of fraudulent claims or questionable practices, this official would act if the facts warranted it. It need hardly be said that your Observer was not favorably impressed and saw no reason why he or the Medical Society should launch an investigation which properly should be undertaken by a government agency.

Since this conversation things have been happening. Both Federal and state agencies have initiated investigations of commercial insurance companies writing hospital and medical expense coverage whose sales methods are open to question. Policyholders, it seems, have discovered that the fine print in their policies invalidated some of the claims made in impressive pamphlets or by fast-talking salesmen.

On August 28, 1953, in an Associated Press dispatch, a Virginia legislative study committee was reported to have recommended that the state hire more investigators to uncover fraudulent sales of health insurance and that additional personnel was required to "take affirmative action to abate abuses and violations of the insurance laws of Virginia."

"Complaints with respect to individual accident and sickness policies," the report stated, "largely pertain to exceptions and to exclusion from coverage, benefits considered by the insured to be inadequate, and cancellations or refusal of the insurer to renew the coverage for reasons which the insured feels are unreasonable and unjust."

In an obvious reference to the fine print which is so often overlooked by policyholders, the committee observed that "inadequate coverage might stem from the insured's lack of knowledge as to his contract and benefits that may be obtained, or incomplete or misinformation given by the insurance agent."

At one point in its report, the committee referred to similar studies pending in other states.

On December 19, 1953, the Federal Trade Commission made it clear that it, too, was concerned about this situation, when it announced a Nation-wide investigation into the sale of hospitalization, health and accident insurance. The Commission said that there were now 800 companies writing health and accident including hospital and medical expense coverage as compared to only 50 in 1925. In 1953, the Commission reported, these companies collected $1,883,999,724 in premiums, an increase of 206 per cent since 1946.

There are about 91½ million persons now covered by some form of hospitalization insurance, 73 million having surgical expense protection and nearly 36 million some form of medical expense protection.

The Commission's investigation will embrace solicitation and sale of liability insurance, including protection, for hospital, surgical, and medical expenses; loss of sight, limb and life; and loss of income due to disability.

No investigation will be made of intra-state companies that are regulated by the several states, but the Commission will bring to the attention of state officials "any matters brought to the Commission's attention which are subject to state instead of Federal law."

The voluntary health insurance movement can ill afford to have in its midst those relying upon fine print to justify their shady practices. It is hoped that the guilty will be eliminated without delay. This is too critical a period for honest commercial insurance companies and nonprofit plans to add unethical practices to their already heavy burden.

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Doctors and the Press

Following the appearance of an item entitled "When a Reporter Calls" in the November, 1953, issue of the MEDICAL ANNALS, your Observer received several communications and telephone calls. Their general tenor was that the advice given was much needed and worthy of repetition.

This was in part the inspiration for further comments on doctors' relations with the press. In your Observer's experience, physicians frequently become disturbed by the critical tone of medical news stories. Admittedly, some of them are disturbing because they contain erroneous statements which, if repeated often enough, come to be accepted as fact. But that is the exception rather than the rule. For there is nothing newspapers shun more than 'old stuff'; news must be up-to-the-minute and have what newspapers call reader interest. On the basis of these conclusions, the following is offered for the consideration of physician-readers:

1. There is nothing as perishable as a newspaper 'story.' Yesterday's news is all but forgotten except by a small minority who because of some personal interest recall what "stood in the paper." There are too many world-shaking events for an ordinary incident to hold more than fleeting attention.

2. Nothing can be gained by keeping alive controversial issues unless they are of such momentous nature as to warrant it. Issuing statements or writing communications to the editor usually serve only to stimulate those who disagree to write more statements and communications.

3. There is no such thing as having 'our side' presented to the exclusion of those who do not agree with us. Most newspapers endeavor to present both sides of an issue, but complete objectivity is rare, human nature being what it is. Reporters, as your Observer has written previously, are influenced in what they write by their background, experience and troubles.

4. It should not be necessary to state that doctors or their medical organizations are not infallible. They make mistakes like everyone else. Some of them are news and a few make the headlines. When this occurs, physicians should submit to the inevitable with good grace.

5. Without wishing to minimize the influence of the press, causes are seldom won or lost because of individual or sporadic news articles. Some years ago, upon the suggestion of the Medical Society, a local newspaper began an investigation of a medical institution with the result that shortly thereafter very critical and highly provocative articles appeared, directing attention to the deplorable conditions which existed in the institution. Six months later your Observer learned that nothing had been done to correct the situation, so he called it to the attention of the newspaper, which again published a series of excoriating articles. Under these circumstances one would think that public indignation would be such that something would be done; but the situation remained as it was for several months thereafter. Even today conditions at this institution are not what they should be.

Long and persistent effort is required to remedy as bad a situation as this was, including the wholehearted and continuous support of one or more newspapers.

In the light of these observations, what should individual physicians and medical organizations do to obtain generally favorable treatment by the press? Here are a few suggestions:

1. They should see to it that the press has knowledge of all constructive efforts made by the medical profession to protect and improve the public health.

2. Where there are injustices, they should see to it that their 'story' is told at the proper time. Negativism, however, can only lead to public disapproval and an unfriendly press.

3. Wherever and whenever conditions warrant, officials of medical organizations should discuss frankly with press representatives the problems facing the profession. Under proper circumstances, this can also be done by individual physicians. In either instance, it may be desirable to do so for the purpose of providing background information only and not with a view of being quoted or credited with supplying the information.

While it is what medical organizations do and not what they say which counts most, it is important that they say what they have to say at the proper time. It is as simple as that!

Heart Patients Can Take Heart

"A large number of people with heart disease, even those who have had a coronary occlusion, live for many years and can safely engage in productive activity," asserts the *Statistical Bulletin of the Metropolitan Life Insurance Company* for October, 1953. It appears, however, that this fact has been overlooked because of the prominence given disability and death due to coronary disease.

In a study of a group of Metropolitan policyholders entitled to benefits because of disability following coronary occlusion during the period 1934–1936, to the anniversaries of their admission to disability in 1952, there were some interesting and encouraging findings. All in the group were seriously ill and apparently permanently disabled when they became eligible for benefits. In view of this, the *Bulletin* points out, "their experience is, therefore, poorer than the average for all cases in the population surviving a coronary attack."

Of the 166 men in the group, about 60 per cent were between the ages 50 and 59 when they became disabled; a little over a third were between 40 and 49, and the remaining few were either under 40 or over 60 years of age. The median age was 51.5 years. Seven out of every 10 lived 5 years or longer following their disability; about half lived 10 years or longer and about one third 15 years or longer.

As might be expected, the 40 to 49-year-group fared better with respect to longevity than those between 50 and 64. Thus at the fifth anniversary of their admission to disability, 75 per cent of the younger group were still living as against 69 per cent of the older. On the tenth anniversary, the percentages were 57 and 47 respectively and at the fifteenth anniversary the percentages were virtually identical—34 per cent for men disabled at ages 40–49 and 33 per cent for older men.

Mortality among the men in this study, the *Bulletin* points out, exceeds that of the average for the lives insured under standard ordinary policies, which is not surprising when the severe character of the impairment and the length of disability are considered.

During a 15-year-period, mortality of the group between the ages 40 and 49 was about 7 times that expected among standard insured risks; in the 50–64 age group it was a little over 3 times the standard. Excess mortality, it is stated, diminished as time elapsed. For all ages combined, the mortality for the first 5 years was 5⅔ times that among standard insured lives, compared with 3 times in the eleventh to fifteenth years following disability.

An appreciable number, the *Bulletin* reports, resumed work in the first 5 years following disability. Twenty-seven or about one sixth of the men returned to work or were judged able to do so by competent medical opinion, the number being greater under the age of 50 than in the older age group.

> "In interpreting these findings it should be kept in mind that many of the men were at or close to normal retirement age and might be reluctant to risk the loss of a benefit that would carry on indefinitely. Furthermore, a considerable number refrained from returning to work simply because they feared that such activity would harm them. Altogether, many of the men who did not go back to work could have done so, and might have been better off if they had.
>
> "On the whole, the picture revealed by these statistics is encouraging. While the adverse aspects of either the immediate or the long-range prognosis in coronary occlusion are not to be minimized, this seriously impaired group illustrates how good the chances are for such patients to survive for many years and to carry on productive activity. It is apparent that the pessimistic attitude regarding the long-range outlook for patients with coronary occlusion is to a large extent unjustified. The results of this study should be reassuring not only to patients and their families but also to physicians and the general public."

★

"The Leaven in the Bread—"

One often hears that so-and-so had a premonition that death was at hand. Usually, something the individual said or did led a relative or a friend to this conclusion. There was no evidence of this in the recent tragic death of Dr. Edward D. Spalding of Detroit. Nevertheless, he left an impressive final 'testament' which his fellow physicians might well ponder.

On December 1, press dispatches relate, Dr. Spalding left his office in Detroit's Professional Building, one among many in the evening rush of persons hurrying home from their day's work. A few minutes thereafter, he lay dead on the pavement, shot, police said, by a former mental patient who got the wrong man.

At noon of the day he died, Dr. Spalding, who was Associate Editor of Wayne County Medical Society's *Detroit Medical News*, submitted copy for what proved to be his last contribution to the Editor's Page of his publication. In it he showed deep concern because it was his belief that physicians generally, and those preparing for a medical career in particular, were losing sight of the fundamental fact that "the cornerstone on which all medical practice rests is that of *personal service*; intelligent and kindly individual attention."

"Medicine as a science," he continued, "has made prodigious strides in the last half century, and yet it seems the more we progress as scientists the more impersonal we become. These two attitudes however are in no sense incompatible, and proficiency in the one in no way requires neglect of the other."

"In years past when the apprentice system prevailed, the young physician starting out had more of an opportunity to observe the professional habits of his senior colleagues in their dealing with patients, and their manners developed through long years of practice. Today the medical student is first saturated with all the latest scientific developments pumped into him in medical school. He is then presented with thousands of proprietary medications furnished him by the pharmaceutical houses, delivered with all the pressure of modern advertising. It is no wonder that soon he is apt to find himself doing a 'land-office business' on a purely commercial level.

"But this is not the practice of medicine as it should be. In the conduct of a practice the physician, in addition to his intelligence and scientific skill, should give something of himself to each patient whom he serves—a *kindly personal human interest*. This is the leaven in the bread that makes the whole loaf of scientific knowledge rise, and without which technical facts become cold fare indeed. It is the lack of just this element which is one of the fundamental faults of the medical profession today, and the reason for much of the social unrest and dissatisfaction with medical service as it is now offered.

"The remedy lies not in public propaganda, published articles, and radio broadcasts, but in the consulting room of every doctor, and how he deals with each and every patient that he sees."

T. W.

THE CLINICAL CENTER*

W. H. SEBRELL, JR., M.D.

Director, National Institutes of Health, Public Health Service, United States Department of Health, Education, and Welfare

It seems most appropriate that the first professional use of this auditorium in the Clinical Center should be the occasion for the Medical Society of the District of Columbia to visit the National Institutes of Health. We welcome this chance to become better acquainted.

In truth, we cannot effectively carry out our medical research function without your coöperation. And we cannot expect your coöperation, your active professional collaboration, until you know and understand our program. These few hours together tonight will help us know and understand each other better. I hope that this occasion will be followed by a continuous, productive relationship.

Your interest in the Clinical Center, as evidenced by the number of people gathered here, is most gratifying. We will do our best to explain the Center to you—what it looks like, what studies are planned and under way, and how this new dimension in our research program relates to medical institutions and the practice of medicine in the Washington area.

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* Read before a special meeting of the Medical Society of the District of Columbia held at the Clinical Center, National Institutes of Health, Public Health Service, in Bethesda, Md., September 23, 1953.

Planning and construction of the Clinical Center have proceéded since 1947. From the beginning we have had certain basic principles as our guide:

1. The Clinical Center is a research center and not a medical care facility.

2. Patients selected as research subjects will be given medical care of the highest quality.

3. The design and operation of the Center foster interchange of ideas and skills of all the major basic laboratory, preclinical, and clinical specialties.

4. Resources of the Clinical Center are available for collaborative research by established scientists from other institutions, and opportunity is provided for able young clinicians to gain specialized training for independent careers in research medicine.

5. In assembling the professional and technical staff, every effort is made to minimize the impact on local medical and educational institutions.

6. In obtaining study patients, close collaboration must be maintained with physicians, hospitals, medical schools, and clinics, the purpose being not to interfere or compete, but rather to permit medical practice, teaching, and research to work together in harmony.

We have been applying these principles for the past five years in the planning stage and are now in the more difficult operational stage. Since the opening of the Clinical Center in July, we have begun studies on approximately 50 patients. We plan to expand our clinical research programs gradually so that there will be perhaps 250 beds activated by next June. Most of our key professional staff is aboard, with technical and supporting personnel arriving in established ratios to patient admissions. In other words, you should soon be able to judge the effect the clinical investigations at NIH will have on your professional lives.

I should like to speak very briefly of the physical plant. The Clinical Center has 6 wings for basic laboratory studies. In addition, the north side of the main stem is largely occupied with clinical laboratories. The central and south portions of the stem contain facilities for the care of 500 study-patients. The space in all three areas, laboratory, clinical and patient, is divided among the 7 Institutes according to their program needs. This space plan has the advantage of permitting a high degree of integration among the many specialties required in research today.

You will have noted that the principal emphasis in our research is on the chronic diseases. It follows that many of our study-patients will remain in the Center for long periods, requiring special facilities for their morale and general well-being. For example, the normal ward has 2 beds, each nursing unit has 13 rooms (with 2 units per floor), and each floor has a branch kitchen to ensure hot and cold food service. The building is air-conditioned, there is a chapel, and there are extensive occupational and recreational therapy areas. You will see some of these facilities when you take a short tour through the Clinical Center at the conclusion of this meeting.

The sole purpose of the Center is to permit research with a high degree of integration and hence greater effectiveness. Our programs begin with a research design. If the investigation involves patients, and if the Medical Board determines that established criteria for protection of the patient's welfare are met, the patients are recruited and the study begins.

This brings us to what I know to be the heart of your interest in the Clinical Center—the study-patient, the physician, and their respective roles in this kind of research enterprise.

First, as to the patients. Before they can be admitted to the Center, they must meet three criteria:

1. They must present diagnoses meeting the specific requirements of a study for which patients are being recruited.

2. They must be referred through professional channels.

3. They (or their parents or guardians) must show a reasonable understanding of their role and a willingness to participate.

To reduce travel cost and to simplify follow-up studies, most patients will be drawn from the Eastern Seaboard, and a great many of those will be from the Washington area. If research need dictates, however, they may come from other parts of the country. We consider the study-patients to be members of a research team, along with our nursing and dietetic staffs and our physicians and investigators. In addition, we believe that the research will be most productive if the referring physician considers himself a part of this team. The study-patient will get the best possible medical care while with us, and, when discharged, will return to the care of his personal physician.

The referring physician will receive periodic reports on the patient's condition. He is welcome to visit the Clinical Center at any time to discuss the patient or the study, and consultation on treatment after discharge from the Center will be available to him on request. His coöperation will be vital during periods of follow-up when appropriate to the project.

We hope to make these relationships informal and highly personalized. Since we received our first patients on July 6, experience has already shown that, for the most part, the physicians and medical care centers in the greater Washington area accept the development of a clinical research program at NIH as a community asset. We will do everything we can to merit a continuation and extension of this confidence.

CLINICAL INVESTIGATIONS AT THE NATIONAL INSTITUTES OF HEALTH*

J. R. HELLER, M. D.

Director, National Cancer Institute, Public Health Service, United States Department of Health, Education, and Welfare

The various research programs of the National Institutes of Health have many things in common, the most important similarity today being to provide a type of tightly integrated laboratory and clinical investigation that is not possible in the usual research environment.

One recalls the work of Goldberger on pellagra; the wide range of studies on infectious diseases carried out at Public Health Service hospitals; studies in the use of promine and other chemotherapeutic agents in the treatment of leprosy at Carville, Louisiana; the clinical trials of new narcotics at the Public Health Service Hospitals in Lexington and Fort Worth; the epochal establishment of penicillin as the drug of choice in the treatment of syphilis; and recent noteworthy studies in cancer and heart disease in Washington, Baltimore, and San Francisco.

The Clinical Center makes it possible for us to continue and extend this kind of investigation—to do it better because we can bring more skills to bear on the problems of disease in man, and to do more of it because the Clinical Center's 500 beds and 1,000 laboratories provide unique opportunity to conduct simultaneous studies in the several promising avenues of approach to the same problem, and at the same time assure that fundamental studies relating to several disease entities do not become narrowly categorized.

We consider it a pleasure and a privilege to have this group visit us, of course. But it is also in our best interests—and, we hope, yours—that there be an understanding not only of our general policies and procedures, but also of the specific areas in which our investigators are working. There have been many instances in the past in which the understanding and collaboration of physicians in the Washington area have contributed significantly to our program. We feel sure that as the Clinical Center moves gradually into full operation there will be more such opportunities, since clinical investigation promises more fruitful areas of coöperation than do basic laboratory studies alone.

It is obvious that I cannot tell you all or even most of the studies which are current in the 7 Institutes. I do think it valuable, however, for you to know the broad scope of each.

In the current program of the Arthritis Institute are clinical studies aimed at the elucidation of certain factors which determine total energy metabolism. These studies lead naturally into the problems of obesity due to overconsumption of food on the one hand and a disturbance of the endocrines on the other. Investigators in this Institute naturally have a vital interest in the arthritic diseases, emphasizing at the present time various aspects of rheumatoid arthritis. Other studies are aimed at the elucidation of the physiologic mechanisms underlying diabetes and a clarification of the interrelationships which exist among the pituitary, the adrenal and the pancreas in the genesis of this disease.

The Heart Institute conducts systematic studies in the field of essential hypertension. These range from the attempt to clarify its underlying causation to an attempt to develop, from either natural or synthetic sources, chemical agents which will modify the disease. Heart Institute scientists are interested in problems related to the underlying mechanism of heart failure and the interplay of endocrine dysfunction in the production of this syndrome. They have a serious interest in the development of new medicinals. These range from antihypertension agents, as previously noted, through mercurial diuretics to anesthetics. Of particular interest in this last research area is an attempt to develop short-acting intravenous anesthetics which are more suitable for use in aging individuals and in individuals with cardiovascular diseases than those currently available.

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* Read before a special meeting of the Medical Society of the District of Columbia held at the Clinical Center, National Institutes of Health, Public Health Service, in Bethesda, Md., September 23, 1953

The Microbiological Institute during the coming year will emphasize studies of brucellosis, of local interest due to the relatively large investment of dairy interests in this area. These investigators will continue and expand their work in the virus diseases which are commonly believed to cause the groups of upper respiratory infections. Their work in poliomyelitis will continue. Here their search is for more effective research preparations which can be used in both the production and the study of vaccines. This Institute, the lineal descendant of the old Hygienic Laboratory, continues to strengthen its reputation in the field of tropical diseases. Of little local importance but of extreme national importance are the studies on diseases which are indigenous to areas from which we draw a good deal of our raw materials. They include such diseases as malaria, schistosomiasis, and onchocerciasis.

In clinical studies of the National Institute of Mental Health emphasis is now on the problems of children, particularly personality derangements that would appear to facilitate the development of schizophrenia. Behavior syndromes relevant to delinquency are being explored, as are possibilities for the treatment of disorders involving excessive aggression. Plans are being refined for studies on adults, with emphasis in such areas as communication in psychotherapy, effects of the hospital environment on schizophrenic patients, and the psychologic evaluation of personality structure. Psychiatric examination of patients with psychosomatic illnesses currently studied for other conditions by the several Institutes will be an important phase of the program.

The Institute of Neurological Diseases and Blindness has undertaken the solution of focal epilepsy as its major program this year. Particular attention will be given to the problem of surgical treatment of temporal lobe seizures. This study, bringing together as it will a team of neurophysiologists, neurochemists, neuropsychiatrists, neurologists and neurosurgeons, will be a major research in this area. It is anticipated that before the end of the present year serious studies will have been undertaken in the field of multiple sclerosis, and studies already are under way in the field of lateral sclerosis. The programs of research on the special senses will begin with investigations in the general areas of cataract and uveitis.

During the five years of operation of the National Institute of Dental Research a significant evolution in the research program has occurred. The major research activities, originally concerned with the causes and control of dental caries, have been broadened to include other interests. The Institute's program now includes fundamental research in such diverse specialties as oral microbiology, ultramicroscopic structure of dental tissues, periodontal disease, chemotherapy and biochemistry, and nutrition. The study of fluoridation of public water supplies has been extended to include not only the relation of fluorides to caries, but to the entire physiology of the body. Projects are under way in such areas as oral tumors, the uses and limitations of chemotherapeutic agents, the effects of radiation on oral tissues, and research in the development and treatment of periodontal diseases.

As Director of the National Cancer Institute, I am naturally more familiar with the work in my own field. I would like to take a single aspect of cancer research and describe it briefly in an effort to demonstrate the research practice which lies behind what may appear to be a highly theoretical phrase, "integrated laboratory and clinical investigation."

I have chosen cancer therapy as the area to develop, since it obviously is of broad general interest to many groups. There are three research areas which appear to have promise in the study of cancer therapy today. They are the study of (1) chemical agents, (2) physical agents, and (3) surgery.

In chemotherapy, for example, under the leadership of Dr. Shear, our investigators have screened many hundreds of compounds to assess their usefulness in cancer therapy. Having established a number of compounds of greatest promise, they are seeking to establish their mode of action, pharmacology, and toxicology preliminary to bringing them to readiness for clinical trial. Our work is, of course, but a part of a large-scale national program of research in the same general field. For the moment, our studies in this field in the Clinical Center are planned to emphasize the leukemias. Related to this work are the promising studies of Dr. Roy Hertz and his colleagues, work which is well known to many of this audience. These studies indicate that sex hormones, such as estrogen and progesterone, modify the course of cancer of the cervix, uterus, breast, and prostate.

The use of physical agents in cancer therapy is demonstrated by studies seeking to find the effects of radiant energy on the phenomenon of cell growth and cell function. These studies range from the observations made on the effect of X-radiation on simple chemical systems, isolated cellular systems, intact cells and organs, and on the body as a whole. These investigators are obviously interested in settling the role of this therapeutic agent in the various neoplastic diseases. There is a study on the extraordinary protection that injection of homologous bone marrow confers on mice and guinea pigs receiving a lethal dose of X-rays, as well as a group of studies specifically related to radiation therapy. The translation of such information to the patient will be looked for with interest.

Probably the greatest advances have been made in the field of surgery, not only because of improved surgical technics, but also because such therapy is more adequate if based on early detection and cancer diagnosis has improved greatly. In the Clinical Center we propose to study advanced surgical technics, particularly relating to the neck and pelvis.

It is readily apparent that a great many of the various organizational units of the National Cancer Institute are linked with the broad field of cancer therapy, extending all the way from the biologic characteristics of cancer cells to the most sophisticated of surgical technics. It is in the ability to blend these many aspects together in common purpose that we find the special promise that lies in the new facilities available here.

In a sense the mechanics of cancer research turn out to be not too different from cancer diagnosis and therapy as practiced in modern hospitals. There, too, it is essential that there be brought together a wide array of skills biochemist, biophysicist, pharmacologist, pathologist, clinician a team of highly trained individuals to provide the ultimate in medical care and medical practice.

We are not afraid of the terms "integrated" and "team" as they apply to NIH research. For certainly, in this framework, there is no loss in individual freedom and no diminution of the values of independent thought and action; and a net gain arises from physical and intellectual proximity to others who bring their specialized talents to bear on common problems.

CORRESPONDENCE

Washington, D. C., October 23, 1953

To the Manager of Medical Bureau

Dear Mr. Zupan:

Thank you very much for your letter of October 16, which explained the new arrangement of the Medical Bureau and the type service that the Bureau is now prepared to give.

At the time that I started into practice 2½ years ago, I became a subscriber to the Telephone Secretarial Service of the Bureau, and though on a number of occasions I have meant to speak to you or Mr. Wiprud about this, up until the present time I have not done so. I earnestly feel that the service tendered me and my associate has not only been good but actually outstanding. I have commented repeatedly to Dr. Klopfenstein and Dr. Tom Wilson, the latter, my former associate who is now in the Navy, about the excellence of the service and the unfailing courtesy shown us by your operators. In addition to this, their intelligent handling of situations that from time to time have arisen has been edifying and actually enables us to feel that your operators have a personal interest in our professional welfare.

As mentioned earlier, I had planned to mention our complete satisfaction which the Bureau has rendered and welcome your letter which has provided the impetus to do so. We are delighted to pay your increased rate and feel that the service rendered represents, in these days of inflated prices, a real bargain.

With warmest personal regards to you and Mr. Wiprud and a sincere vote of thanks to the operators of the Medical Bureau, I remain,

Sincerely yours,
James C. Walsh, M.D.

On the Lighter Side

Doctor, this is your page! You are going to be pleasantly surprised at this interesting new departure from the old and usual form of contents in the MEDICAL ANNALS. Thanks to the members of the Editorial Board, this page will be a monthly feature of the ANNALS, and will be devoted to the human and lighter side of the "Doc" who so ably represents the District of Columbia Medical Society in the fields of medicine and surgery.

This assignment was given to your reporter too late to get adequate material together before the current deadline; therefore, this first article will be our method of acquainting all the members of the District of Columbia Medical Society with the idea behind the birth of this particular page so that all who read may help to keep it living.

What type of news do we want here? We want news that will be of interest to all of us who relish a little of the lighter side with their heavy medical and scientific fare. 'Names make news,' therefore give to us the names of our colleagues who relax with a hobby or who compete in a sporting event. Tell us who goes fishing and brings back the biggest fish, or who it is that goes hunting and bags the most game. Let us know who among us is a real pool "shark," or who is the champion of the card table. For instance, we find it interesting to know that Dr. "Pete" Moran likes to don the red coat and the peaked hat to ride after the hounds. We like the story of how Drs. Alec Preece, J. C. Waters and Clyde Reeves bruised their shoulders and froze their feet while sitting in a rocking rowboat and trying to shoot the elusive duck. For instance, we enjoyed hearing how Dr. James Kane is learning the Italian language by sleeping on a special pillow that duns the words and phrases into his ear.

Sports of all types are of universal interest. We thought it interesting to know that Dr. D. Franklin Hodge walked away from the University Club's recent Bowling Meet with the highest score and his pockets jingling with all the prize money. Our own District of Columbia Medical Bowling League has been very active. The team standings as of January 15, 1954 are as follows:

Casualty	30-12
Suburban	27-15
Sibley #2	26-16
Sibley #1	25-17
Washington Hospital Center	25-17
George Washington	23-19
Georgetown	23-19
Children's	22-20
Columbia	21-21
Prince Georges	19-23
Emergency #2	19-23
Doctors	17-25
Emergency #1	15-27
Good Hopers	15-27
Garfield	14-28
Providence	13-29

The Bowling League has arranged for prizes with the Meredyth Pharmaceutical Co., the District Wholesale Drug Corporation, and the Peoples Drug Stores, Inc. Prizes of worthwhile merchandise from the above companies have been given each 6-weeks period to the doctor who has achieved the highest score for an individual game, to the doctor who has obtained the second highest score for an individual game, and to that doctor who has compiled the highest individual score for a 3-game bowling set.

The doctors who have won these personal achievement awards to date are: Dr. J. Phelps Hand, with a high game score of 170; Dr. Ambrose H. Cook, with the second highest game score of 163; and Dr. Andrew J. Betz, with a high score set of 383. The second 6-weeks session resulted in merchandise prizes for the following bowlers: Dr. A. J. Connolly with a high game of 141; Dr. Gordon R. MacDonald, with the second highest game score of 139; and Dr. Millard F. Ottman, sweeping the boards with a high score set of 375.

The bowling team which has won distinction to date is Children's captained by Dr. Frank Bacon. This exceptional team has won the honor of both high team game of 638, and of high team set of 1,699. Much credit must be given to the other members of Children's team, namely, Drs. Ambrose H. Cook, Thomas J. Pekin, Israel Kessler, John W. Nesbit and George A. Resta.

From the above, you can see that we have the beginning of what could be an interesting and lively page of news on the lighter side. Now, in order to

(Continued on page 132)

News and Personals

MEETINGS—Past and Future

The George Washington University School of Medicine announces its ninth annual series of **Intensive Postgraduate Courses** for the month of March. Three fields will be covered, Gynecology, March 1–5; Cardiovascular Diseases, March 15–19; and Surgical Diagnosis, March 29–April 2, under the direction of Dr. John Parks, Dr. Clayton B. Ethridge, and Dr. Brian Blades, respectively. The courses will be presented in the Conference Room of the University Hospital. The fee for each course, $75.00, will include, in addition to the tuition, a dinner and a bound set of mimeographed notes covering the various presentations. Enrollment should be made through the Director of Postgraduate Instruction, George Washington University School of Medicine, 901 23rd Street, N.W., Washington 7, D. C.

Coördinated with the postgraduate program will be the annual **Kellogg Lectures,** which are planned primarily for physicians in this area and for which there is no charge. These lectures will be presented in Hall A of the School of Medicine, 1335 H Street, N.W., beginning at 8:30 p.m. The program for the series follows:

March 3: "Terminal Care for the Gynecologic Cancer Patient," Dr. Norman Fritz Miller, Professor and Head of the Department of Obstetrics and Gynecology, University of Michigan

March 15: "Pathogenesis and Management of Coronary Atherosclerosis," Dr. Thomas Morton Durant, Professor of Clinical Medicine, Temple University School of Medicine

March 17: "Emotional Problems in Heart Disease," Dr. Edward Weiss, Professor of Clinical Medicine, Temple University School of Medicine

March 29: "Management of Visceral Trauma," Dr. Edward Mather Kent, Associate Professor of Surgery, University of Pittsburgh

April 1: "Problems in Abdominal Surgery in Infancy and Childhood," Dr. Mark Mitchell Ravitch, Director, Department of Surgery, Mount Sinai Hospital; Clinical Professor of Surgery, Columbia University College of Physicians and Surgeons

Dr. Thomas M. Peery, Director of Postgraduate Instruction, states that during the academic year 1952–53, some 180 physicians attended postgraduate courses offered by the George Washington University School of Medicine, exclusive, of course, of those who were present for the Kellogg Lectures. The physicians enrolled came from 22 states and the District of Columbia. There were 5 physicians enrolled from foreign countries.

The 22nd Annual Assembly of the Southeastern Surgical Congress will attract many Washington physicians to Birmingham, Alabama, March 8–11, 1954. The meetings will be held at the Dinkler-Tutwiler Hotel.

Four panel discussions are planned, one for each day, 4:30 to 5:30 p.m. the first three days and from 12:30 to 1:30 p.m. the fourth day. The subjects for discussion are (1) Traumatic Lesions; (2) Esophagogastrointestinal Hemorrhage; (3) Liver and Gallbladder Pathology; (4) Surgical Management of Peptic Ulcer. Dr. Harry Lee Claud, immediate Past President of the Congress, will be moderator for the third panel discussion, March 10.

Two Washington physicians are listed among the speakers, Dr. Donald Stubbs, who will present a paper on "Cardiac Arrest, Prevention and Management," and Dr. J. Ross Veal, who will speak on "The Role of Vaso-constriction in Prolongation of Shock."

The Washington Heart Association is sponsoring an **Institute on Cardiac Rehabilitation** for nurses, social workers, and therapists, to be held on Thursday, March 18, from 1 to 5 p.m., in the auditorium of the D. C. Medical Society. Appearing on the program will be Dr. Josephine Buchanan, Director of Physical Medicine, D. C. General Hospital; Dr. W. Proctor Harvey, Assistant Professor of Medicine, Georgetown University Hospital; Miss Margaret

Luden, Director of Social Service, Georgetown University Hospital; Miss Jane Wilcox, Chief, Heart Nursing Service, Clinical Center, National Institutes of Health; Mr. Earl Kline, Consultant on Selective Placement, Bureau of Employment Security; Dr. Andrew G. Prandoni, Chairman of the Cardiac Work Evaluation Unit; and Mrs. Carroll Lewis, Occupational Therapist with the Washington Heart Association.

It is hoped that physicians will encourage all personnel with whom they are connected to attend these sessions. Further information may be obtained by calling Mrs. Lewis at the Washington Heart Association, Sterling 3-1397.

The District of Columbia Society for Crippled Children is sponsoring a series of professional lectures at the Society's headquarters, 1767 Massachusetts Avenue, N.W., from 3:30 to 4:30 p.m. The subjects for January and February were listed in the January issue of the Medical Annals. The topics scheduled for presentation during March and April are shown below:

March 3: "Anatomical Basis for Rorschach, Mosaic and Gestalt Variants in Brain Damage," Othmar Solnitzky, Ph.D., M.D., Professor of Anatomy and Head of the Department, Georgetown University School of Medicine

March 11: "Childhood Schizophrenia," Dorothy Donley Dowd, M.D., Clinical Associate Professor of Pediatrics, in Psychiatry, Georgetown University School of Medicine

March 16: "Behavior Problems in Children," Thelma Hunt, Ph.D., M.D., Professor of Psychology and Executive Officer, George Washington University

March 23: "Psychosomatic Aspects of Brain Damage," John R. Cavanagh, M.D., Clinical Associate Professor of Medicine, Georgetown University School of Medicine

March 30: "The Education of the Brain-damaged Child," Mrs. Miriam Tanhauser, Supervisor of Special Education, Montgomery County

April 6: "The D. C. Public School System and the Brain-damaged Child," Carl Hansen, Ph.D., Assistant Superintendent of Schools, District of Columbia

April 27: "The Future of the Brain-damaged Child," James F. Garrett, Ph.D., Director of Program Services, United States Department of Health, Education and Welfare.

The Washington School of Psychiatry is sponsoring three series of lectures during the winter months. The lecturers are **Dr. Winfred Overholser, Dr. Edward J. Stieglitz, and Dr. Frieda Fromm-Reichmann,** all members of the District Medical Society. The series by Dr. Overholser, on Psychiatric Jurisprudence, were announced in the January issue of the Medical Annals.

Dr. Stieglitz will give 10 lectures weekly on Tuesdays, February 2 through April 6, at National University, 1225 New York Avenue, N.W., 8 to 9 p.m., on **The Problems of Aging.** The charge for the series is $15. His subject matter will concern: orientation to the social problems of aging; changes that occur in normal senescence; risks encountered in the process of aging; heart disease; nutritional problems; predictable emotional and physical stresses in aging; stresses related to work and retirement; senility as a problem; factors retarding or cultivating maturation; and implications of emotional maturity.

Dr. Fromm-Reichmann will give three lectures on **The Creative Assets of the Mentally Handicapped** at the Cosmos Club, 2121 Massachusetts Avenue, N.W., February 19, March 5 and 19, 8 to 9:30 p.m. The fee for the series is $10.

Reservations for any of the lectures should be made by mail or phone to the Washington School of Psychiatry, 1711 Rhode Island Avenue, N.W., Sterling 3-4373.

The 22nd Annual Postgraduate Clinic of the D. C. Dental Society will convene at the Shoreham Hotel, March 14–17, 1954. Members of the District Medical Society are invited to attend the scientific sessions. Dr. Arthur Dick will be moderator for a panel discussion on What Is the Effect of Dental Foci of Infection on Health; discussors will include Dr. Thomas McP. Brown and Dr. Sterling V. Mead. Dr. Murray M. Copeland will be among the discussors for a panel discussion on Oral Cancer—the Dentist's Responsibility.

Eight national organizations will present the highlights of some of the current dental research proj-

PSYCHIATRIC SOCIETY HONORS DR. LAUGHLIN

DR. HENRY P. LAUGHLIN (second from right) receives a certificate of commendation from the Washington Psychiatric Society, January 8, upon retiring as President of the Society. DR. KENNETH E. APPEL (left), President of the American Psychiatric Association, presents the certificate to Dr. Laughlin. Between them is DR. DOUGLAS NOBLE, newly inducted President of the WPS. To the right of Dr. Laughlin is DR. WINFRED OVERHOLSER, Past President of the APA.

ects now in progress in their respective groups. Entitled "Research in Action," this feature will occupy the entire West Ballroom. Those attending the Clinic are urged to see this panorama of dental research which will be complete with actual research equipment, laboratory demonstrations and exhibits.

The Sixth Annual Meeting of the Washington Psychiatric Society was held in the Medical Society's auditorium, January 8. Dr. Kenneth E. Appel, of Philadelphia, President of the American Psychiatric Association, was present to speak on "Fundamental Considerations in Psychiatric Treatment." At the conclusion of his address, Dr. Appel, in behalf of the Washington Psychiatric Society, presented Dr. Henry P. Laughlin with a certificate of commendation for having "faithfully served the Society in the capacity of President."

At the business session preceding the lecture, Dr. Laughlin gave a brief report on the Society's activities. The incoming President, Dr. Douglas Noble, was officially inducted into office. Dr. Laughlin will serve as a member of the Council for one year. New officers elected were:

Dr. Marshall deG. Ruffin, *President-elect*; Dr. Seymour J. Rosenberg, *Secretary*; Dr. Norman Taub, *Treasurer*; Drs. Reginald S. Lourie and Julius Schreiber, *Council members*.

A committee of Mrs. Rex Buxton, Chairman, and Mmes. Douglas Noble, Leon Salzman, and Hewitt I. Varney were hostesses during a social hour in the library which followed the meeting.

Doctors and their wives filled the auditorium of the District Medical Society, January 6, to hear a panel discussion on **Emotional Problems of Adolescence.** Moderator for the meeting was Dr. Donald A. Block, Chief of the Children's Units, Clinical Investigations Branch, National Institute of Mental Health, Public Health Service. Panel participants were Dr. Dorothy Donley Dowd, Associate Professor of Psychiatry and Pediatrics, Georgetown University School of Medicine; Mrs. Elizabeth H. Ross, Deputy Chief, Children's Bureau; Dr. Carl F. Hansen, Associate Superintendent, Elementary Division I, Public Schools of the District of Columbia; and Mr. Paul R. Cherney, Executive Secretary, Family and Child Welfare Section, United Community Services.

The Section on Gastroenterology of the Medical Society of the District of Columbia sponsored a panel discussion on Acute and Chronic Pancreatitis in the Medical Society's auditorium, February 10. Dr. Robert J. Coffey, Professor of Surgery, Georgetown University School of Medicine, was moderator for the panel. Panel members were Dr. Leonard W. Weyl, Washington, who presented the etiology of the disease under discussion; Dr. Moses Paulson, Baltimore, who spoke on diagnosis; and Dr. R. F. Bowers, Memphis, Tenn., who discussed its management.

At the regular dinner meeting of the **Washington Gynecological Society,** December 5, Dr. Bernhard Zondek was the guest speaker. He discussed "Some

Problems Concerning Ovarian Function." Dr. Zondek is Professor of Gynecology and Obstetrics and Director of the Hormone Research Laboratory, Hadassah School of Medicine, Hebrew University, Jerusalem, Israel.

At the meeting, January 20, Dr. C. K. Fraser, Chairman of the District Medical Society's Obstetrical Board, summarized the Board's report on maternal mortality, which covered a five-year study period, 1950–54.

The George Washington University Medical Society held its regular meeting, January 20, at 1335 H Street, N.W. The guest speaker was Dr. Chester S. Keefer, Special Assistant to the Secretary for Health and Medical Affairs, Department of Health, Education and Welfare; he is also Physician-in-chief of Massachusetts Memorial Hospital and Professor of Medicine, Boston University. Dr. Keefer addressed the members on the subject, "Government Responsibility in the Health of the Nation." Dr. Luther H. Snyder, President of the Society, presided at the meeting.

The Jacobi Society held its monthly meeting, December 21, in the Washington Hotel. A departure from the usual type of program was a series of five-minute talks on a variety of subjects by the following members of the Society: Drs. Daniel J. Abramson, Maynard I. Cohen, Bela Gondos, Morton S. Kaufman, Jack L. Levine, Benjamin Manchester, Lawrence E. Putnam, Isadore Rodis, Monroe J. Romansky, Morris H. Rosenberg, and Sydney Ross. In such a program more members of the Society are given an opportunity to express themselves on topics of interest to the entire membership.

The Georgetown University School of Medicine has initiated a series of alumni lectures which will feature talks by distinguished alumni living in other areas of the country. The first speaker was **Dr. Leo H. Bartemeier,** noted psychiatrist, who spoke, January 20, on "Attitudes of the Physician and the Medical Student."

Dr. Bartemeier graduated from Georgetown School of Medicine in 1920. He is a Past President of the American Psychiatric Association and the American Psychoanalytic Association. He was trained in psychiatry at Detroit's Henry Ford Hospital and at Johns Hopkins Hospital, Baltimore. An Associate Professor of Clinical Psychiatry at Wayne University, Detroit, Dr. Bartemeier holds international lectureships at Dublin, Ireland and Havana, Cuba. He is the Chairman of the Committee on Mental Health of the American Medical Association.

The Editorial Board of the MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA held its annual dinner meeting, January 11, at Pierre's Restaurant. Dr. Wallace M. Yater, Editor of the ANNALS, presided. Present were Theodore Wiprud, Managing Editor, A. Louise Eckburg, Assistant Editor, and the following members of the Editorial Board: Drs. Frederic G. Burke, Frank D. Costenbader, Hugh H. Hussey, Winfred Overholser, Thomas M. Peery, Herbert P. Ramsey, R. Lee Spire, and Donald Stubbs.

The Clinical Society of the Diabetes Association of the District of Columbia met, January 21, at the home of the Society's Secretary, Dr. Samuel D. Loube. Dr. Loube presented a paper at this meeting on "Current Status of the Hyperglycemic Factor of the Pancreas."

On January 18, Dr. Gerald McAteer was host to the **George Martin Kober Medical Society** at the Army-Navy Club. Dr. William M. Ballinger presented the topic for discussion, "Gall Bladder Disease."

GENERAL NEWS

At the meeting of the **Executive Board of the Medical Society of the District of Columbia,** December 28, 1953, Drs. Clifford E. Bagley and James J. Feffer were appointed to the Classification Committee.

At the request of the Washington Academy of Sciences for a nominee to serve as Vice President of the Academy representing the Medical Society, the Board reappointed Dr. Frederick O. Coe to serve in that capacity.

The Secretary reported to the Board that the Reference Committee on Amendments to the Constitution and By-laws of the AMA had voted that any Active member of the American Medical Association who had failed to pay dues for the year 1950 and who was suspended for such delinquency may be reinstated during the first 6 months of 1954 by payment of 1954 dues only. Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent.

The National Multiple Sclerosis Society and the National Institute of Neurological Diseases and Blindness are distributing an attractive, illustrated pamphlet entitled **"Multiple Sclerosis Patient."** They are asking the coöperation of physicians in bringing the pamphlet to the attention of the patient and his family, health educators, social workers, nurses, and others for whom this disorder may be of deep concern. Copies of the pamphlet may be obtained in limited quantities by writing to the Public Inquiries Branch, Public Health Service, Department of HEW, Washington 25, D. C.

The American Cancer Society, District of Columbia Division, is sponsoring the showing of the film, **"Breast Self-Examination,"** each third Wednesday, March 17, April 21, May 19 and June 16, at the Perpetual Building Association auditorium, fourth floor, 1111 E Street, N.W. There will be two showings, one at 1 p.m. and the other at 1:30 p.m. Admittance tickets for physicians' patients are available by calling the American Cancer Society, Executive 3-3690. These cards may be placed in his waiting room, or distributed in any manner he sees fit.

Georgetown University is the recipient of five new **grants from the United States Public Health Service,** totaling $72,599. Two projects will be supervised by Dr. Francis M. Forster, Dean of the School of Medicine: $24,250 for a teaching and training grant in neurology, with the objective of increasing the number of young neurologists in training in the Washington area; $16,000 for an evaluation of new anticonvulsant drugs by the Georgetown Epilepsy Clinic. A grant of $7,500 will be used by Drs. Charles E. Rath and Laurence H. Kyle for a study of ascorbic acid metabolism in leukemia; $15,984 by Dr. Charles A. Hufnagel for a cardiovascular and cardiovascular replacement project; and $8,865 by Dr. Roger Baker for a study of the mechanism of abnormal calcification, with emphasis on kidney stones.

Mr. Clayton R. Sanders, advertising director for Peoples Drug Stores, has been named **General Chairman of the American Cancer Society's 1954 Crusade** in the District of Columbia, which will be held during the month of April. Mr. Sanders was Public Relations Chairman of the 1952 Cancer Crusade. He is a member of the Board of Trustees for the District of Columbia Division of the American Cancer Society, a member of the Washington Board of Trade, the D. C. Pharmaceutical Association, and the Veteran Druggists Association.

Officials of **Hospital Center Corporation** gathered on the grounds of Soldiers' Home, December 30, as work began on surface grading, construction of roads, and clearing of the site for the new hospital. Mrs. William L. Welsh and Mrs. Millard Tydings, wife of the former Senator from Maryland, who are credited with the idea for the hospital center, were present as was Mr. Charles S. Dewey, President of the Hospital Center.

Jango capping exercises were held in the Medical Society's auditorium, January 11. Dr. Donald Stubbs, of Doctors Hospital, opened the meeting and introduced the speaker, Rear Admiral Don S. Knowlton, MC, USNR. Caps and certificates were awarded to a class of 36 members by Mrs. Helen M. Newton, Director of Nursing, and Dr. Edgar A. Bocock, Administrator, both of Doctors Hospital. To receive a cap each Jango must have completed 24 hours of class work and 76 hours of floor duty in the Hospital within 3 months.

Five Jangos received white chevrons for completing 200 hours of volunteer duty, 4 received blue chevrons for 300 hours, and 3 received red chevrons for 500 hours of duty. The last three were the Misses Maria Ecker-Racz, Cecile Hanley and Elspeth Norgaard. The latter's mother, Mrs. Rollo Neil Norgaard, is Senior Counselor of the Jangos and awarded the chevrons to the 12 young women so honored.

PERSONALS

Dr. Thomas McP. Brown, Professor of Medicine, George Washington University School of Medicine, served as visiting Chief of Medicine at the Atlantic City (New Jersey) Hospital during the week, November 23–27, 1953. This is the fourth year he has taken part in this hospital's training program, which is designed to make available the latest in medical training and education for the hospital's interns and residents as well as for practicing physicians in the Atlantic City area. The plan is set up to relieve some of the problems created by the lack of a medical school in New Jersey; as part of the plan, prominent medical authorities are invited to the hospital each week to lecture, make rounds and teach.

Dr. Brown gave five lectures; the subjects were: "Certain Considerations in Diagnosing and Management of Gout," "Further Studies in the Management of Rheumatoid Arthritis," "The Diagnosis and Management of Brucellosis Arthritis," "Nonmedicinal Aspects Important in the Management of Arthritis," and "Diagnostic Criteria in the Clinical Separation of Various Types of Collagen-Vascular Diseases."

Dr. William J. Tobin, Associate Professor of Orthopedic Surgery, Georgetown University School of Medicine, presented a paper on "The Internal Architecture of the Femur—Its Clinical Significance," before a meeting of the American Academy of Orthopaedic Surgeons in Chicago, January 25. Dr. Tobin has been conducting for some years a study on gross osteopathology, and the internal architecture of bone as a joint endeavor, with the Smithsonian Institution, Armed Forces Institute of Pathology, and the Georgetown University Medical Center. The James Picker Foundation for Radiological Research has assisted in this study.

Dr. Brian Blades, Professor of Surgery at George Washington University School of Medicine, spoke on "New Concepts in the Treatment of Tuberculosis" at the University of Kansas School of Medicine in Kansas City, Kansas, January 20. The lecture was part of a postgraduate medical course offered at the Medical School, January 18–21, in conjunction with the Kansas State Medical Society and the American College of Surgeons.

The Washington Gynecological Society was ably represented at the Clinical Meeting of the American Academy of Obstetrics and Gynecology in Cincinnati, December 13–17. **Dr. Andrew Marchetti** was Chairman of the Program Committee for the meeting. Round table discussions were conducted by **Drs. Samuel M. Dodek, Raymond T. Holden, Joseph B. Sheffery and John W. Walsh.** Dr. Dodek conducted two on Cesarean Section; Dr. Holden, one on Uterine Inertia and Prolonged Labor; Dr. Sheffery, Analgesia and Anesthesia in Obstetrics; and Dr. Walsh, X-ray Pelvimetry. **Dr. John L. Parks** presided at a round-table discussion on Rooming-in.

Other members of the Society who attended the meetings were Drs. Jed W. Pearson, Harry S. Douglas, Christopher J. Murphy, Jr., and Philip P. Steptoe.

Dr. Charles S. Wise, Professor of Physical Medicine and Rehabilitation, George Washington University School of Medicine, was the principal speaker on the University of the Air radio program, December 9. He discussed "Psychological Elements in Physical Rehabilitation." This program was one of a series sponsored over radio station WCFM by George Washington, Georgetown, and Howard Universities, St. John's College, and the University of Virginia.

Dr. Frank Brown Berry, New York City, has been appointed **Assistant Secretary of Defense for Health and Medical Affairs** by President Eisenhower. Dr. Berry was Professor of Clinical Surgery at Columbia University College of Physicians and Surgeons. He succeeds in office Dr. Melvin A. Casberg, who announced his resignation, January 13, and who is returning to private practice after serving in the office of Assistant Secretary for the past two years.

Theodore Wiprud, Executive Director and Secretary of the Medical Society of the District of Columbia, addressed the Pulaski County Medical Society, Little Rock, Arkansas, on January 4, 1954; his subject, "Who Pays The Doctor?" Preceding his talk, he spoke to the senior medical students at the University of Arkansas.

On January 13, Mr. Wiprud began a series of lectures to the senior class of Georgetown University School of Medicine on the following subjects: "Medical Practice—Today and Tomorrow," "Careers in Medicine—a Panel," "Office Management," "Handling of Patients' Accounts," "Professional Conduct," and "Some Medico-Legal Problems." Participating in the panel discussion on "Careers in Medicine" will be: Dr. Michael J. McInerney—private practice; Dr. Lawrence A. Pyle, Jr., Assistant Medical Director, Chesapeake and Potomac Telephone Company—industrial health; Dr. Thomas M. Peery, Director of Postgraduate Instruction, George Washington University School of Medicine—medical education; and Dr. W. H. Sebrell, Jr., Director, National Institutes of Health, Bethesda—public health.

Dr. Eugene deSavitsch reports that while he was in London, England, recently, H.R.M. King Peter of Yugoslavia, in exile, decorated him with the Order of St. Sava in recognition of the professional services rendered to his subjects in exile.

Dr. Aubrey O. Hampton was moderator for a panel discussion on "The Future Evolution of Teaching in Radiation Therapy" at the 21st Annual Conference of Teachers of Clinical Radiology, held under the auspices of the Commission on Education, American College of Radiology, at the Drake Hotel, Chicago, February 6. Dr. Hampton is Chairman of the Commission on Education of the College.

Dr. Worth B. Daniels was elected Vice President of the Society of Medical Consultants to the Armed Forces at its Eighth Annual Meeting in Washington, November 23. Dr. Richard A. Kern, of Philadelphia, assumed the office of President, succeeding Dr. John Minor.

Dr. Carmon R. Naples has been appointed Commander of Alcantara Caravan No. 12, Order of the Alhambra, of the Knights of Columbus. Dr. Naples is an alumnus of Georgetown University School of Medicine and an Active member of the District Medical Society.

Dr. Lawrence E. Putnam, Associate in Medicine, George Washington University School of Medicine, discussed "Fundamentals of Antibiotic Therapy" at the intern staff meeting at Emergency Hospital, November 2.

Mr. F. Royce Franzoni, President of the American Pharmaceutical Association, was one of the principal speakers at the annual national convention of the Kappa Psi professional pharmaceutical fraternity, which was held in Washington at the Sheraton-Park Hotel, December 28-30. Mr. Franzoni is head of the Z. D. Gilman Pharmacy at 627 Pennsylvania Avenue, N.W., and an Associate member of the District Medical Society.

Dr. Christopher T. Bever, formerly Director of the Montgomery County Mental Hygiene Clinic at Rockville, Maryland, has moved to North Carolina to accept a position as Associate Professor in the Department of Psychiatry, School of Medicine, University of North Carolina. He will also be Associate Attending Physician at the North Carolina Memorial Hospital and Director of the Psychiatric Outpatient Research, Training and Treatment Center.

Dr. Stanley W. Bergreen writes the Secretary of the Medical Society from Kaneohe, Oahu, T. H., where he is Supervising Psychiatrist at the Territorial Hospital.

Dr. David F. Bell, Jr., now in Staunton, Virginia, is staff pathologist at King's Daughters' Hospital.

BOOK REVIEWS

Modern Treatment; A Guide for General Practice. By fifty-three authors. Edited by Austin Smith, M.D., Editor of *The Journal of the American Medical Association,* and Paul L. Wermer, M.D., Secretary, Committee on Research, American Medical Association. Price, $20.00. Pp. 1146. New York: Hoeber, 1953.

The rapid pace of progress in the management of diseases has made it an Herculean task to keep abreast of new developments in therapy. The 53 contributors to this treatise have managed to create a volume which presents the practical essentials of current treatment of conditions likely to be encountered by the general practioner. The list of contributors is impressive and authoritative. Their wide experience in the various specialties makes their therapeutic approach unquestioned. Wherever alternative forms of treatment are discussed, there are attempts at an evaluation in order to select the most practical and effective one. Discussions of etiology, pathology, and clinical manifestations are of necessity either absent or brief but the rationale of therapy is always accorded its proper place.

There are several interesting chapters devoted to diagnostic tests arranged according to the various body systems. A brief orientation on diagnostic radiology is included which carefully appraises the usefulness as well as the uselessness of this frequently employed diagnostic aid. Principles of surgery, pharmacology and immunology are discussed in separate chapters to serve as a guide in the use of special therapeutic aids. The closing pages list normal clinical laboratory values arranged alphabetically for quick reference.

This outstanding book can be highly recommended.

Sol Katz, M.D.

Monographs in Medicine. Edited by William B. Bean, M.D. Price, $12.00. Pp: 655. Baltimore: Williams & Wilkins, 1952.

Medical monographs are popular among physicians for they represent a form of medical writing more thorough than the average journal article and yet not as exhaustingly complete as a book. This collection of 15 monographs encompasses such a variety of topics that most physicians are likely to find herein several subjects of interest.

There are several monographs in this volume which merit special consideration. "Precordial Noises Heard at a Distance from the Chest" is a delightful and fascinating discussion of the many diverse disorders which may cause this startling phenomenon. Much useful clinical data are included. "The Physiology of Body Fluids" is presented clearly with emphasis on the disturbances seen in clinical medicine. This section should be especially appealing to those who are seeking a practical approach to a difficult subject.

"Angiocardiography" contains a discussion of the technic and practical diagnostic applications. The illustrations are clear, numerous, and accompanied by labeled line drawings.

"Portal Hypertension" contains a complete review of the background leading to the present concepts, considers some of the difficulties in diagnosis as well as an evaluation of current methods in treatment.

In "Pheochromocytoma," although emphasis is given to physiologic and pharmacologic studies, the clinical picture, diagnosis and management are also presented.

"Respiratory Failure in Neuromuscular Disorders" presents a review of the theoretical and experimental data necessary to understand the development and treatment of respiratory insufficiency. In addition there is a lucid outline of the clinical management and prevention of respiratory decompensation occurring in diseases affecting the neuromuscular system.

This series contains 5 monographs related to infectious diseases and perhaps would be considered too heavily weighted in this subject by most physicians. However, these topics are timely and adequately presented.

All of the articles are written by authorities with a view of being most useful for the practicing physician. In addition to being informative, this volume has a beautiful format and is attractively bound.

Sol Katz, M.D.

BOOKS RECEIVED

Acknowledgment is made of the following books which have recently been received. Selections will be made for more extensive review in the interests of our readers and as space permits. Physicians are urged to submit reviews of additional current books which, in their opinion, merit comment.

Proceedings of the First and Second Medical Conferences of the Muscular Dystrophy Associations of America, Inc. held in New York, N. Y., April 14–15, 1951 and May 17–18, 1952. Edited by Ade T. Milhorat, M.D., Departments of Medicine and Psychiatry, Cornell University Medical College.

Science and Man's Behavior. The Contribution of Phylobiology. Including the complete text of **The Neurosis of Man.** Trigant Burrow, M.D., Ph.D. Edited by William E. Galt, Ph.D. Price, $6.00. Pp. 564. New York: Philosophical Library, Inc., 1953.

Review of Physiological Chemistry, 4th ed. Harold A. Harper, Ph.D., Professor of Biochemistry, University of San Francisco; Lecturer in Surgery, University of California School of Medicine, San Francisco; Biochemist Consultant to Metabolic Research Facility, U. S. Naval Hospital, Oakland; Biochemist Consultant to St. Mary's Hospital, San Francisco. Price, paper, $4.00. Los Altos, Calif.: Lange Medical Pub., 1953.

The History of the Medical Department of the United States Navy in World War II: A Compilation of the Killed, Wounded and Decorated Personnel. Foreword by Lamont Pugh, Rear Admiral, M.C., Surgeon General, U. S. Navy. Navmed P-5021, Volume 2. Pp. 235. Washington, D. C.: United States Government Printing Office, 1953.

Breaking Patterns of Defeat. The Effective Readjustment of the Sick Personality. Richard L. Jenkins, M.D., Chief of Psychiatric Research, Psychiatry and Neurology Service, Veterans Administration, Washington, D. C. Price, $6.75. Pp. 270. Philadelphia: Lippincott, 1954.

The Psychiatrist: His Training and Development. Report of the 1952 Conference on Psychiatric Education held at Cornell University, Ithaca, New York, June 19–25, 1952. Organized and conducted by the American Psychiatric Association and the Association of American Medical Colleges. Editorial Board: JOHN C. WHITEHORN, M.D., *Chairman*; FRANCIS J. BRACELAND, M.D., VERNON W. LIPPARD, M.D., AND WILLIAM MALAMUD, M.D. Price, $2.50. Pp. 214. Washington, D. C.: American Psychiatric Association, 1953.

School Health Services . . . A Report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the coöperation of contributors and consultants. CHARLES C. WILSON, M.D., Editor, Professor of Education and Public Health, Yale University. Price, $5.00. Pp. 486. Washington, D. C.: National Education Association, 1953.

Visceral Circulation. A Ciba Foundation Symposium. G. E. W. WOLSTENHOLME, O.B.E., M.A., M.B., B.CH., Editor for the Ciba Foundation. Assisted by: MARGARET P. CAMERON, M.A., A.B.L.S., AND JESSIE S. FREEMAN, M.B., B.S., D.P.H. Price, $6.50. Pp. 278, with 72 illustrations. Boston: Little, 1953.

Salt and the Heart. EDWARD T. YORKE, M.D., Attending Cardiologist, Alexian Brothers Hospital; Associate Cardiologist, St. Elizabeth Hospital; Dispensary Physician, Elizabeth General Hospital, Elizabeth, N. J.; Consultant in Medicine, Rahway Hospital, Rahway, N. J. Price, $3.75. Pp. 83. Linden, N. J.: Drapkin Books, 1953.

JAMES GEORGE McKAY, M.D.

(1871–1953)

Dr. James G. McKay, a Life member of the District Medical Society, died, November 15, 1953, at Mount Vernon Hospital following a long illness. He was known affectionately to many of his patients as "Dr. Jimmie." He opened his office in the 1700 block of S Street, N.W., in 1903, and later moved to 2009 Columbia Road, N.W., where he lived and practiced. He retired, because of ill health, in 1952.

Dr. McKay was born in Stockton-on-Tees, Durham County, England, July 26, 1871, and came to the United States with his parents at an early age. He attended Granville (Ohio) Academy and was graduated from Denison University. He received his medical degree from the University of Pennsylvania with honors in 1895. He was an honor student at the University of London in 1909 and at the University of Edinburgh in 1911.

He served with a medical unit during the Spanish-American War and later he served in the Philippine Insurrection. On the way to the Philippines his unit was diverted to China where it participated in the Boxer Rebellion. In the Philippines he served in the Third and Eleventh Cavalry.

During World War I, Dr. McKay was surgeon to the Tenth Engineers with the rank of Major. Later he was with the 42nd Division in charge of installing first aid stations on the firing line in France. After the Armistice was signed, he was made Chief Surgeon to the city of Nancy, an American leave area.

He was one of those to plan and supervise the building of a 1,000-bed hospital at the Old Soldiers' Home, Fort Monroe, Va.

His wife, Mrs. Mabel Rakestraw McKay, died in 1947. They had traveled extensively and were among the first visitors to the World War I cemeteries in France.

In 1904 he became a member of both the Medical Association and the Medical Society of the District of Columbia, and a Life member of the Society in 1945. He was a member of the American Medical Association.

Membership in fraternal organizations included the Carabao, the Spanish War Veterans, the American Legion, Beta Theta Pi fraternity, Denison University Alumni Association, Washington Alumni Association of the University of Pennsylvania, the Washington Golf and Country Club, and the Masons in Ohio. He was a charter member of the University Club.

Survivors are a niece, Mrs. R. E. Dietrich, Bridgeport, Pa.; and two nephews, James M. Weitzell and H. W. Weitzell, Jr., Pittsburgh, Pa.

FRANK EUGENE GIBSON, SR., M.D.

(1873–1953)

Dr. Frank E. Gibson, Sr., native Washington physician and a Life member of the District Medical Society, died, December 20, 1953, at his home, 5306 Audubon Road, Bethesda, Maryland. For almost half a century he had practiced medicine in the Washington area.

Dr. Gibson was born in Washington, D. C., November 16, 1873, the son of the late John Floyd Gibson and Minnie Knapp Gibson. He was educated in the District schools and high school. After graduation from Columbian College, now George Washington University School of Medicine, in 1899, he was intern and later resident physician at Garfield Memorial Hospital, 1899 to 1901. He was on the staff at Garfield until 1912. He practiced in the District of Columbia from 1901 until he retired in 1947.

Dr. Gibson became a member of the old Medical Association of the District of Columbia in 1901 and of the Medical Society in 1902, and a Life member in 1942. He was also a member of the American Medical Association. As treasurer of the Washington Medical and Surgical Society since 1903, he was devoted to the activities of that organization and was made Permanent Treasurer. The Society awards a prize in his name each year for the outstanding scientific paper presented by one of its members.

In his younger years, Dr. Gibson was active in many drilling organizations. He wrote a book, "Gibson's Fancy Drills," which outlined maneuvers he invented.

Club memberships included the B.B. French Lodge No. 15, Columbia Chapter No. 1, Royal Arch Masons, Albert Pike Consistory No. 1, Scottish Rite Masons, and Almas Temple. He had served as grand treasurer of the Grand Commandery, Knights Templar of the District of Columbia.

Surviving are his wife, Mrs. Frances M. Gibson, and a son, Dr. Frank E. Gibson, Jr., both of the home address. Dr. Gibson, Jr. is also an Active member of the District Medical Society.

SAMUEL CHARLES WOLDENBERG, B.S., M.D., M.Sc.

(1893–1953)

Dr. S. Charles Woldenberg died, December 17, 1953, at his home, 4520 Salem Lane, N.W., after a long illness. He had maintained offices at 1726 Eye Street, N.W.

Dr. Woldenberg was born, October 14, 1893, in Germany and received his early education there. He became a citizen of the United States in 1918. He received his medical degree from Chicago Hospital College of Medicine (now Chicago Medical School) in 1918 and a Bachelor's degree in Science from Marquette University the following year. He also held a Master's degree in Science from Iowa State College, 1923. He interned at Madison General Hospital, Madison, Wisconsin, and took his residency training in orthopedic surgery at Massachusetts General Hospital, Boston, and Children's Hospital, Iowa City, Iowa.

Dr. Woldenberg was associated with Dr. Phillip H. Kreuscher of Chicago in the practice of orthopedic surgery for six years. He was attending Orthopedic Surgeon at Postgraduate Hospital, Chicago, from 1925 to 1930, and Attending Orthopedic Surgeon at Michael Reese Hospital and Dispensary, Chicago.

Joining the Veterans Administration in 1931, he was in charge of Orthopedic Service until 1940, when he was commissioned Colonel in the Army Medical Corps. During his Army service he was Chief Surgeon at LaGarde General Hospital, New Orleans, and Nichols General Hospital, Louisville, Ky. He was released from active duty in 1945, and set up private practice in Washington.

He was elected to Active membership in the Medical Society of the District of Columbia in 1944. He was a member of the American Medical Association, the Clinical Orthopedic Society, and the Ambulatory Fracture Society.

Dr. Woldenberg contributed a number of articles in his field of medicine to medical journals; he was the author of a book entitled, "The Prevention of Orthopedic Deformities with Special Reference to the Spine and Feet."

Surviving are his wife, Mrs. Dorothy Brindze Woldenberg; a daughter, Miss Diane Woldenberg, of Washington; and a brother, Adolph Woldenberg, of Chicago.

WESLEY CINTRA COX, A.B., M.D., Dr.P.H.

(1891–1953)

Dr. Wesley C. Cox, retired Army medical officer, died in Richmond, Virginia, May 22, 1953, while serving on active duty.

Dr. Cox was born in Brooklyn, New York, April 21, 1891, the son of the late Henry Edward Cox and Addie Cintra Cox. He received his A.B. degree from Columbia College, New York, in 1913 and his medical degree from the Columbia University

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College of Physicians and Surgeons in 1916. Subsequently he took graduate training at the Army Medical School in Washington, D. C., and Johns Hopkins University, Baltimore. From the latter he received the degree, Doctor of Public Health, in 1939.

He began his Army career in 1917 when he joined the Medical Corps Reserve as First Lieutenant; the following year he was commissioned First Lieutenant in the Regular Army; during his 36 years of service he held posts as Chief of the Laboratory, Camp Jackson, S. C., in 1921; epidemiologist, Fort Dix, N. J., 1921–22; serologist and chief, laboratory, Eighth Army Area, 1926–31; chief, laboratory, and medical inspector, Fort Leavenworth, Kan., 1931–34. He was bacteriologist and instructor, 1917–21, and bacteriologist, serologist, and instructor, 1925–26 at the Army Medical School, Washington, D. C., and bacteriologist and instructor, Walter Reed General Hospital, 1934–37. He served in the Panama Canal Department as bacteriologist in 1922, leaving in 1925 and returning in 1939 to spend seven more years in the Canal Zone. He served as Assistant Surgeon, Headquarters, Caribbean Command, 1946, and retired, April 30, 1951.

He was awarded the Legion of Merit, the Army Commendation ribbon, and by the President of Panama, the Order of Vasco Nuñez de Balboa, Grade of Commander. He was commanding officer of the Army Environmental Health Laboratory at the Army Chemical Center, Edgewood, Md.

He was a diplomate and a member of the founders' group of the American Board of Preventive Medicine and Public Health; a fellow of the American College of Physicians, the American Public Health Association, the American Geriatrics Association; a member of the American Medical Association, the American Society of Tropical Medicine and Hygiene, Industrial Medical Association, American Association of Industrial Hygienists, and the Association of Military Surgeons of the United States. He had been an Associate member of the District Medical Society since 1949.

Rehabilitation of Alcoholic Patients—Zappala

(*Continued from page 95*)

CONCLUSIONS

The medical profession has finally entered the activities of research education and therapy in the problems of alcoholism. The widely accepted concept that alcoholism is a sickness, primarily mental, secondarily physical, places continued responsibility upon medical practitioners to seek more satisfactory approaches to treatment.

The etiology of alcoholism is complex, and multiple factors are involved. The essence of the problems related to alcoholism is certainly altered behavior upsetting the balance of interpersonal relations and therefore is psychologic in nature.

The attitude of the physician, therapist, or fellow alcoholic is basic in achieving coöperation from the alcoholic patient. This process is often challenging, prolonged, and painful for patient and therapist.

A multi-pronged approach to the rehabilitation of the alcoholic patient by many disciplines, medical, sociologic, psychologic and religious appears presently to be the most promising. The Health Department of the District of Columbia is taking leadership in this direction.

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2. BACON, S. D.: Alcoholism: nature of the problem. Federal Probation, 1947, **11**, nos. 1 and 2.

Overconcern with Health—Laughlin

(*Continued from page 105*)

into hypochondriacal concerns the real ones are less apparent. Also less energy is available to act upon disapproved sexual or aggressive impulses. Primary and secondary gains are present, of which the latter may be painfully apparent to an external observer.

(*To be continued*)

On The Lighter Side

(*Continued from page 121*)

keep this page alive and vibrant we must have news concerning doctors who have hobbies, who play hard at golf and bowling or at other sports, and of doctors who have tales to tell of prowess in the field or on the stream. If you know of such a doctor, drop a line concerning him or her to "On The Lighter Side," 1718 M Street, N.W., and your reporter will follow your lead and get the facts for the MEDICAL ANNALS.

J. EARL KADAN, M.D.

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STUDY ON THE EFFECT OF OVERDOSES OF PENTYLENETETRAZOL AND PENTOBARBITAL SODIUM COMBINATIONS IN HUMAN SUBJECTS

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IT WAS previously demonstrated in 6 subjects that from 10 to 12 therapeutic doses of the pentylenetetrazol and pentobarbital sodium combination, each dose containing 100 mg. of pentobarbital sodium and 300 mg. of pentylenetetrazol,* ingested in a single dose, showed delay in onset of sleep and restlessness for approximately 3 hours after ingestion. Three of these subjects retched and vomited. The use of pentylenetetrazol in combination with barbiturates for the prevention of acute barbiturate poisoning has been recommended.[1-4]

Notwithstanding the latter results, it was thought that a further effort to explore the effects of even larger doses of this combination that could be ingested at one time with safety should be undertaken. Accordingly, the present report is concerned with an additional 10 subjects who voluntarily ingested simultaneously amounts of pentylenetetrazol and pentobarbital sodium in a ratio of 3 to 1. The amount of barbiturate ingested by the subjects in this study has previously been considered fatal by some authors.[5-8] We[2] have shown in a recent publication that pentylenetetrazol alone in doses smaller than those ingested by the subjects who volunteered in this project produced convulsions; and there are data in the literature that equal or smaller doses of pentobarbital sodium than were used in the present study may result in coma or even death.

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* TetroPENTObarb 400 capsules were supplied through the courtesy of Strong, Cobb and Company, Inc., Cleveland, Ohio.

Materials and Method

Ten adult male subjects, weighing between 140 and 200 lbs., were given postabsorptively from 13 to 20 capsules at a single dose, each capsule containing pentobarbital sodium 100 mg. and pentylenetetrazol 300 mg. The total single administered dose contained, therefore, from 1,300 to 2,000 mg. of pentobarbital sodium in combination with from 3,900 to 6,000 mg. of pentylenetetrazol.

Extreme care was taken that each subject swallowed and retained the entire dose, which was completely ingested within 1 minute. The volunteers were never left alone, and even if they went to the lavatory one of the investigators accompanied them to make sure that they did not resort to emetic measures to regurgitate the drug. This prevention of vomiting does not apply to the later states of pentylenetetrazol action when the vomiting reflex becomes uncontrollable. The subjects were kept under constant observation for 48 hours following the ingestion. Blood was drawn at various intervals, and barbiturate levels were estimated according to Goldbaum's method.[9]

Results

The results of the study are embodied in table 1. All of the subjects exhibited some signs of mild acute barbiturate intoxication, strongly resembling those of alcoholic intoxication. They either remained awake until their usual bedtime, or were easily aroused if they had fallen asleep. In the latter case they were able to respond to questions, sometimes without effort, other times slowly and in a dysarthric manner. They all showed ataxia in gait and station, nystagmus, both horizontal and vertical, and difficulty in accommodation. In some subjects there was a positive Babinski. Otherwise, superficial and deep reflexes were normal in all subjects. Blood pressure, pulse and respiratory rates were not significantly changed from the normal pattern.

Evidence of central nervous system stimulation was observed in most but not in all subjects. Seven out of 10 subjects showed nausea, retching and vomiting within 1 to 4 hours after ingestion. Frank convulsions were never seen, but in 4 subjects involuntary clonic jerks and torsion spasms were noted. It is worthy of mention that these signs were not seen in the subjects who ingested the largest number of capsules.

Discussion

Oral doses of pentobarbital sodium of the magnitude ingested by our subjects have been shown to produce anesthesia, coma, or even death. The blood barbiturate levels obtained in these subjects, particularly in those who did not vomit, are considered as being in the comatose range. Fisher, Walker and Plummer[10] have reported lower levels in comatose patients following the ingestion of pentobarbital sodium alone. Krantz and Carr[7] state that 1 Gm. (15 gr.) of pentobarbital is the maximum nonfatal dose for humans. All of our subjects ingested more than this dose and 2 received double this dose. Anderson[11] states that 12 times the therapeutic dose of barbiturates is necessary for severe poisoning. Hambourger's data,[5, 6] frequently referred to, indicate that 14 mg. per kg. of pentobarbital sodium is the oral LD_{50} for humans. Some of our subjects ingested twice this amount, but in combination with pentylenetetrazol.

We[2] have previously shown that the oral Convulsant $Dose_{50}$ of pentylenetetrazol is between 3.0 and 3.6 Gm. (total dose) and that all of these subjects showed retching and vomiting preceding the convulsions. All of the subjects participating in the present investigation ingested higher doses of pentylenetetrazol without

TABLE 1

Effect of Oral Administration of Pentobarbital Sodium and Pentylenetetrazol Combinations (Tetropentobarb)

SUBJECT (INITIALS)	AGE	WEIGHT	TOTAL DOSE PENTOBARBITAL SODIUM INGESTED*	TIME OF ADMINISTRATION	TIME OF VOMITING AFTER ADMINISTRATION	BLOOD BARBITURATE	REMARKS
		kg.	*mg.*			*mg. per liter*	
W. M.	29	68	1,300 (13 capsules)	12:40 p.m.	2 hrs. 3½ hrs.	30 min.— 0.0 1 hr. — 2.0 2 hrs. — 5.0 3½ hrs. — 5.5 6 hrs. — 5.5 12 hrs. — 4.0 24 hrs. — 3.5	2:40 p.m.: went to bed; 3:20: was sleeping but easily aroused; 4:30: well oriented but complained of upset stomach.
R. M.	36	91	1,300 (13 capsules)	10:20 a.m.	No vomiting at any time	30 min.— 0.0 1 hr. — 4.5 2 hrs. — 9.0 3½ hrs. —11.5 6 hrs. — 9.0 12 hrs. — 8.0 24 hrs. — 6.0	Did not go to bed until his usual bedtime. Appeared rational and alert; slightly dysarthric; his gait was somewhat unsteady.
S. H.	47	64	1,600 (16 capsules)	10:30 a.m.	3 hrs.	30 min.— 3.5 1 hr. — 7.0 2 hrs. —10.5 3½ hrs. —12.5 6 hrs. —13.0 12 hrs. —11.5 24 hrs. — 8.5 36 hrs. — 6.0	1:45 p.m.: went to bed; 2:35: was asleep but easily aroused; spoke; 4:30 p.m.: rational.
J. J.	39	65	1,600 (16 capsules)	10:00 a.m.	2¾ hrs. 3¾ hrs.	30 min.— 0.0 1 hr. — 1.0 2 hrs. —10.0 3½ hrs. —13.5 6 hrs. —13.5 12 hrs. —11.6 24 hrs. —10.0 36 hrs. — 6.5	From 12:20 to 4:00 p.m.: clonic jerks—he was aware of them. 4:00: he talked and dozed off.
J. T.	44	69	1,600 (16 capsules)	10:15 a.m.	1½ hrs. 2 hrs. 2¾ hrs.	30 min.— 1.8 1 hr. — 5.5 2 hrs. — 7.5 3½ hrs. — 8.0 6 hrs. — 7.5 12 hrs. — 6.5 24 hrs. — 5.5 36 hrs. — 3.0	12:45 p.m.: clonic jerks; 4:30 p.m.: complained of frontal headache; sat up in bed and asked what time it was.
J. G.	35	65	1,700 (17 capsules)	10:30 a.m.	45 min. 55 min. 1½ hrs.	30 min.— 3.5 1 hr. — 7.0 2 hrs. — 9.0 3½ hrs. — 9.0 6 hrs. — 9.0	Never went to sleep. Could always walk but with a slight ataxia.

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* The total dose of pentylenetetrazol in each case was 3 times that of the barbiturate. It varied, therefore, from 3.9 Gm. to 6.0 Gm.

TABLE 1.—(*Continued*)

SUBJECT (INITIALS)	AGE	WEIGHT	TOTAL DOSE PENTOBARBITAL SODIUM INGESTED*	TIME OF ADMINISTRATION	TIME OF VOMITING AFTER ADMINISTRATION	BLOOD BARBITURATE	REMARKS
		kg.	*mg.*			*mg. per liter*	
T. H.	38	75	1,800 (18 capsules)	10:40 a.m.	No vomiting at any time	30 min.— 4.0 1 hr. —10.0 2 hrs. —17.0 3½ hrs. —18.0 6 hrs. —17.5 12 hrs. —14.0 24 hrs. —12.5 36 hrs. —12.0	12:10 p.m.: torsion spasms and occasional clonic jerks; 1:55: smoked cigarette with assistance; 4:15 p.m.: responded to questioning; sat up in bed.
J. B.	27	73	1,800 (18 capsules)	10:15 a.m.	No vomiting at any time	30 min.— 1.3 1 hr. — 7.5 2 hrs. —11.0 3½ hrs. —11.8 6 hrs. —17.0 12 hrs. —14.1 24 hrs. —10.8 36 hrs. —10.3	12:00 p.m.: dysarthria; 12:15: walked around with assistance; 4:15 p.m.: asleep, but easily aroused; occasional torsion spasms.
J. F.	26	77	2,000 (20 capsules)	1:35 p.m.	3 hrs. 3¾ hrs.	30 min.— 0.0 1 hr. — 1.5 2 hrs. — 5.5 3½ hrs. — 9.2 4½ hrs. — 9.5 6 hrs. — 9.0 12 hrs. — 8.5 36 hrs. — 5.5	2:40 p.m.: went to bed because of dizziness; 5:00: fell asleep; easily aroused, rational; 7:00: same as at 5:00; 1:00 a.m.: same; 11:00 a.m.: drowsy; walked about; tried to vomit; no twitches or torsion spasms.
L. Y.	34	92	2,000 (20 capsules)	1:40 p.m.	3¾ hrs.	30 min.— 0.0 1 hr. — 1.5 2 hrs. —12.5 3½ hrs. —15.5 4½ hrs. —14.0 6 hrs. —13.0 12 hrs. —12.0 36 hrs. — 8.0	3:00 p.m.: dizzy; 3:20 p.m.: went to bed and slept restlessly; 8:00 p.m.: able to walk with assistance; 1:00 a.m.: rational; no complaints other than being sleepy. No evidence of twitches or torsion spasms throughout experiment.

showing frank convulsions, but 7 of the 10 vomited. Some pentylenetetrazol effects, e.g., vomiting, occurred from 1 to 4 hours after ingestion of the TetroPENTObarb, while nausea in some cases lasted for as long as 24 hours. We have previously reported on the prolonged effects of pentylenetetrazol when ingested in large doses.

The mechanism of protection may be twofold: (a) a central stimulant antagonizing the effects of a central depressant, and (b) a central stimulant exciting the vomiting center in the presence of large amounts of barbiturates. The latter is not surprising in view of the early report of Schwartz[12] showing the ability of pentylenetetrazol to denarcotize the emetic mechanism.

SUMMARY

Our present results indicate that in humans pentylenetetrazol, when incorporated in the definite proportion of 3 to 1 with pentobarbital sodium, affords protection against toxic doses of the latter. The doses used contained as much as twice the amount of the barbiturate usually held to produce severe poisoning in humans.[7, 11]

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THERAPY IN EPILEPSY*

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IN THE entire field of neurology there is no disease of greater importance than epilepsy. This is very quickly realized when one considers that epilepsy is a chronic disease, and, therefore, that the patients are sufferers over a long period of time. Secondly, this is statistically a most important disease, since one out of every 200 of the total population has seizures. This means that in an area as populous as Greater Washington, there are approximately 7,000 epileptics. This, of course, in view of the number of patients, is a far greater problem than the neurologist can handle, and, moreover, these patients need not and should not be the concern only of the neurologists. The physicians in general practice must be equipped to handle the great majority of these patients. It is only the unusual patient who is refractory to therapy, or who presents a diagnostic problem that comes within the immediate realm of the neurologist.

It is quite easy to divide the history of therapy in epilepsy into several eras. The first might be called the era of mysticism, with the treatment in that era consisting of amulets, incantations, and similar spiritually oriented therapies. This was the period in which seizures were considered evidence of demoniacal possession by obviously bad spirits, or sometimes considered evidence of activity by good spirits. For example, in the Roman Senate the appearance of a seizure called for adjournment *sine die* as the sign of the gods that no more business was to be transacted on that day. So it is therefore quite easy to see why, in this era, the predominance of therapy was directed toward incantations, amulets and similar remedies.

Following this period came an era of empiricism without rational basis. There began a weaning away of the concepts of mysticism as to etiology, and whatever heavy metals or alkaloids or other preparations entered into the pharmacopoeia were tried on an empiric basis. The next period was that of empiricism with some rationale. This was the sedative era of anticonvulsants and began in 1857 with Sir Charles Locock.[1] The rationale for the introduction of bromides by Locock was that patients who had seizures, in his opinion, had excess sexual venery, and he gave them bromides to decrease their sexual venery. To his surprise he found that the seizures were decreased. This, mind you, coincided with the dawn of neurology as we know it. This bromide therapy was the mainstay until the year 1912, when phenobarbital was introduced by a Q.E.D. type of thinking. Hauptmann[2] computed that bromides are sedatives, bromides are good for seizures, and since phenobarbital is a sedative, therefore phenobarbital should be good for seizures. In this manner phenobarbital was introduced. How fortunate it was that the first of the barbiturates uncovered was phenobarbital and not one, such as seconal, with little or no anticonvulsant activity.

Next occurred the beginning period of neuropharmacology. Neuropharmacology is a new science, hardly well recognized yet, seldom referred to by the term of neuropharmacology, and yet the next great advance after neurobiochemistry in the total field of neurology. This field had its inception in the minds of Putnam and Merritt,[3] who were concerned with the fact that patients taking phenobarbital or bromides, although their seizures were frequently controlled, were often rendered too sleepy and too sedated to be useful citizens in the community. It occurred to these neurologists that perhaps sedation and anticonvulsant effects were not reciprocal, but were merely interdependent, and that if this were so, a drug developed in the sedative realm but which had failed to be a sedative might well prove an efficacious anticonvulsant.

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To test this hypothesis they obtained samples from the pharmaceutical houses of drugs meant to be sedatives but which had failed to render people drowsy, determined in a series of cats what the convulsive threshold of electroshock was, administered these nonsedative sedatives to the cats, and determined which ones increased the seizure threshold. They then chose the three of these most successful in the animal experiments, screened them for their toxicity, and then began their use on the wards and the outpatient department of the Boston City Hospital in 1937–38. This culminated in their paper on the use of sodium diphenylhydantoinate before the American Medical Association in June, 1938.

In our sister field of psychiatry in this period metrazol-induced seizures were employed with treatment of patients with psychiatric illnesses. Toman[4] and Goodman began the use of screening of drugs by the metrazol induction method in animals and found, rather surprisingly, that dilantin itself gives little protection against metrazol seizures in animals but that certain other drugs protect very well against these, notably tridione and paradione. Lennox's success with tridione[5] in the treatment of petit mal epilepsy led to the conclusion that those drugs in animals which protect against electrically induced seizures are successful clinically in major convulsions, while those which protect against metrazol in the seizures of animals are successful in the field of petit mal epilepsy. Based on the neuropharmacologic concepts plus the actual clinical experimentation in patients otherwise refractory, there has evolved a series of drugs.

The next era of anticonvulsant medication is difficult to predict, but in view of the investigative work going on in various places at the present time, it seems quite possible that the studies of enzyme neurochemistry and perhaps of the carbon tagging technic will lead us to better understanding of the site of action and the modus operandi of anticonvulsant drugs. We may certainly look forward to better and more effective anticonvulsants.

How can we as physicians apply these advances made by neurologists in the field of epilepsy? The first aim in handling the individual patient is to establish the fact that the patient does not have a disease requiring a specific treatment. This means that brain tumor, subdural hematoma, and general paresis must be ruled out. Each of these has its own specific treatment, and the treatment of seizures in these instances is actually secondary to the treatment of the disease.

The next point in the handling of the patient is the determination of the seizure type. This is necessary because the type of medication is dependent upon the type of seizure from which the patient suffers. For all general purposes of treatment we can very simply divide the kinds of seizures into major seizures, petit mal, and psychomotor. In the first category of major seizures are included the generalized seizures, which are due to idiopathic or essential epilepsy, and the focal seizures, which are on the basis of symptomatic epilepsy but which are to be treated medically. The petit mal seizures are the short attacks of children lasting usually less than 50 seconds, characterized by short stares or myoclonic jerks and occasionally by falling. Psychomotor seizures are more prevalent in adults. These last usually several minutes, during which the patient carries out some irrelevant but purposeful activity and cannot remember this activity. It is during these seizures that patients walk several blocks talking irrelevantly to their colleague, or drive a car a mile or two beyond their destination, or find that they have gone to the store and purchased articles for

TABLE 1

Standard and Experimental Drugs for Epilepsy

TYPES OF ANTICONVULSANTS	STANDARD AVAILABLE PREPARATIONS	EXPERIMENTAL PREPARATIONS
HYDANTOINATES	Sodium diphenyl hydantoinate (Dilantin) Methyl-phenyl-ethyl-hydantoin (Mesantoin) Phethenylate sodium (Thiantoin) (discontinued)	Methyl-phenyl-hydantoin (Nuverone) (discontinued)
OXAZOLIDINES	Trimethadione (Tridione) Dimethyl ethadione (Paradione)	Allylmethadone (Malidone)
BARBITURATES	Phenobarbital Mebaral Gemonil	Mysoline
ACETYLUREA	Phenylacetylurea (Phenacemide, Phenurone)	
FLUID BALANCE AND MINERAL BALANCE	Glutamic acid and its sodium salts Resins	
OTHERS		Benzylchloropropinamide (Hibicon) Methylphenylethylsuccinimide (Milontin)

which they have no use, and in all of these instances are amnesic afterwards.

TABLE 2

Indications of Standard Drugs in Epilepsy

GRAND MAL PSYCHOMOTOR PETIT MAL	Dilantin Phenobarbital Mesantoin Tridione Paradione Phenurone
GRAND MAL	Dilantin Phenobarbital Mesantoin Tridione Paradione Phenurone Mysoline
PSYCHOMOTOR	Dilantin Phenobarbital Mesantoin Tridione Paradione Phenurone Mysoline
PETIT MAL	Dilantin Phenobarbital Mesantoin Tridione Paradione Phenurone Milontin

Table 1 lists the anticonvulsant drugs in their groupings. This includes both the standard drugs and the known experimental drugs. Table 2 shows the indications of the standard drugs in the control of seizures.

The best hydantoinate, from the standpoint of effectiveness and nontoxicity, is sodium diphenyl hydantoinate, and the best barbiturate is still phenobarbital. The oxazolidines, in general, are useful only in the treatment of petit mal epilepsy and are contraindicated in the use of major epilepsy. By the same token, the hydantoinates are usually contraindicated in the treatment of petit mal epilepsy. Phenacemide, or phenurone, is restricted in its use to psychomotor seizures and for focal seizures in infants with a progressive increase in neurologic or psychiatric deficit. The Abbott Laboratories is to be particularly commended for the judicious way in which it introduced and described phenacemide in its distribution literature. This is an extremely dangerous drug with a high incidence of severe psychiatric complications, particularly depressions. In addition to that, it is also dangerous from the standpoint of blood dyscrasia and hepatic diseases. However, it has a particular usefulness in patients with psychomotor seizures when those seizures cannot be controlled by any other drug.

Let us turn now to the new medications which are not yet on the market but which will probably be sufficiently useful and sufficiently safe to reach the open market. The most important of these is Mysoline. This drug is an Imperial Chemical Industries product which has been in the hands of investigators for about two years. Bushnell Smith and I[6] have found at the Georgetown University Epilepsy Clinic that this drug is extremely useful in the control of major seizures and is of considerable value in the treatment of psychomotor epilepsy. As a matter of fact, in view of the toxicity of phenurone, it is our impression that Mysoline should be tried when dilantin and phenobarbital are unsuccessful and before phenacemide is employed. This drug comes in tablets of 0.25 gram each, and we usually begin by adding Mysoline to the patient's other medication. The patient who is taking 0.4 or 0.5 gram of dilantin a day and perhaps some phenobarbital without success has Mysoline added to the other medication in a single dose a day, and then if seizures continue, a second dose, and so on. The top dose that can be used is 10 or 11 tablets per day.

The toxicity of Mysoline is not serious. There are a few patients who, on taking the first dose, become very ataxic and nauseated and may vomit for hours. They, of course, never take more than the first dose. This occurs in about 1 out of 40 patients. There are other patients who, on taking Mysoline, become extremely drowsy. This occurs in about 1 out of 10 patients. Ordinarily the drowsiness is not dependent on the dosage taken, since it does not matter very much whether the patient is on 1 or 3 tablets a day. This drowsiness wears off in about 3 to 4 days and the patient becomes alert again even though the medication is continued. We encountered in our series of 100 patients, 14 patients in whom Mysoline had to be stopped because of nausea or persistent drowsiness. There have been no hematologic or renal complications up to the present time in our series. According to others, there are 2 cases of leukopenia which are not well documented because there is some confusion as to the other drugs which the patients were taking at the same time. We have, however, encountered a rather peculiar psychiatric complication in 2 patients. One of these, while taking 2 tablets a day, had a moderate control of seizures, but on 3 tablets, which entirely controlled her seizures, she became paranoid and hostile toward her parents. When the dose was reduced to 2, the hostility and paranoid trends disappeared. The dose was returned again to 3 tablets per day. The psychiatric manifestations again appeared and again disappeared when the dosage was reduced.

Of the newer drugs, Milontin, which is a succinimide, is rather efficacious in the treatment of petit mal epilepsy. Bushnell Smith and I[6] found in our series of 50 patients who were refractory to the use of tridione or paradione, that improvement of seizures occurred in 27 with Milontin. This is a rather peculiar drug and in our hands has not been successful over a protracted period of time. Often patients who are controlled for a period of time will lose their control and gain a tolerance. This is the only drug in the anticonvulsant series to which I am convinced the patients develop a tolerance. Frequently it is said that patients become tolerant to their anticonvulsant drug. This may appear to happen in children, but actually it is not a matter of tolerance but merely a matter of outgrowing a child's dose. Often, when it is said to have occurred in an adult, it is really a problem of the patient's decreasing his dosage.

Another new drug called Malidone has been described in the English literature and is similar to paradione and tridione in its chemical structure and in its anticonvulsant activity. It apparently has no great advantage over tridione, but if it becomes marketed, it would be indicated in those patients with petit mal epilepsy not properly controlled by tridione, paradione or Milontin. Milontin, however, would seem to have some advantage over Malidone in the fact that there are so few toxic instances reported. Only one investigator has reported renal complications and leukopenia as a result of Milontin therapy.

Another new drug, Hibicon, or chloropropinamide, apparently has some anticonvulsant effect, particularly in grand mal seizures, but at the present time it does not appear to be superior to dilantin, phenobarbital or Mysoline.

There are a number of other anticonvulsant preparations not yet beyond the experimental number stage.

From the purely medical therapy of epilepsy, there is considerable hope, both in the present and in the future. We know that the judicious use of the drugs mentioned can control the seizures in 85 to 90 per cent of patients. With the developments outlined for the future in the neuropharmacologic field, as well as the further plumbing of our empiric clinical trials based albeit on some reason, it is certainly obvious that newer and better medications are forthcoming. Whether or not we will ever have an all-purpose anticonvulsant that will control all seizures remains to be seen. Most of us in the field of neurology hold a rather dim view of that and think that it is always going to be necessary to select the drugs carefully. Also, it seems unlikely at this time that there will ever be a one-shot kind of therapy, that is, a medication that is given once or for a short period of time and will permanently prevent seizures. This would be a godsend, but in view of the episodic nature of epilepsy, both clinically and electrophysiologically, that concept seems at this time somewhat unlikely. With the great developments in the field of medical neurology and in its basic disciplines, we may all look forward with hope to the control of seizures in the 10 to 15 per cent of patients who at the present time cannot be controlled.

Obviously, not only is the future outlook good for medical therapy, but the present status is far from discouraging. One of our major problems, however, in the treatment of epilepsy is that of the social and economic situation. With the broadened activities of physicians, it is important that we assay our role in this field also. It is now necessary for physicians to be active in their social and community life to a greater degree than ever before. In both small and large communities doctors must serve on the school boards, advisory committees to the local Government agencies, advisory councils of state governments, and so on. There are increasing responsibilities to our epileptic patients in this area. This is best pointed out by the patient who comes to the epilepsy clinic, and when you look up and smile at him and say, "Isn't it wonderful that you haven't had a seizure now for 6 months," and he replies, "What difference does it make; I still can't get a job." We must do our part to offset the stigma that is still attached to this disease. We are in the third or at least in the beginning of the fourth therapeutic era since the mystical stigma era, and yet the hangovers of that era still result in difficulties in job placement, school placement, mate selection, and other avenues of normal social intercourse. The epileptic is a normal person the great majority of the time. The man who has 2 seizures a year is perfectly competent except for 10 minutes twice a year. The restrictions are not only in the minds of the people, they are in the lawbooks of the Nation. There are states in which it is illegal for an epileptic to marry. In most states there is difficulty in obtaining a driver's license. The compensation insurance laws do not allow the second injury clause in most areas, so that these people cannot be profitably employed. It will perhaps be of interest to you to know that the American Epilepsy League took an active interest in this very field, and as President in 1952 I appointed a legislative committee headed by Dr. Howard Fabing of Cincinnati, Ohio, who immediately drew legal support from Dean Barrow of the University of Cincinnati College

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ACNE VULGARIS—THE SCOURGE OF YOUTH

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MORE than half of all youths are affected by acne vulgaris. In many cases it is mild and self-limited, healing without appreciable evidence of its tenure. Yet, all too often it is severe, with many blackheads, pus-capped red papules, and cystic lesions of varying sizes. These in the untreated case often persist for months to years and when they heal leave behind deep pits and disfiguring scars. Acne is so prevalent in our country that it probably causes as much if not more human suffering than any other one disease. Adolescence is a critical time for every youth, and any change which renders a person less socially acceptable cannot help but have serious social and economic aspects for both the individual and society.

All too often the ravages of acne are laid down in the wake of neglect. This disease should be treated and treated early. Never must the patient be dismissed with a few encouraging words to comfort him and a casual remark to the parents that the child will outgrow it. The earlier therapy is instituted, the less likely will there be scarring. Usually it is the family doctor whose aid is first sought, and it is well within his province to treat many of the cases of acne.

The cause of acne is still unknown. It develops during the period of gonadal activity and must bear some relationship to the hormonal products of these organs. At one time it was thought that an increase in androgen was causative, since it was known that eunuchs did not get the disease but it could be induced in them by giving androgens. However, acne has occurred after estogren administration. Consequently, the most widely held concept today is that of Lawrence and Werthessen,[1] who postulate as causative a disturbance of androgen/estrogen ratio, with androgen predominating.

Pathogenetically, the sebaceous glands under this dyshormonal influence become overactive, their outlets become plugged, and comedones or cysts develop. The cysts become infected by bacteria, tissue destruction occurs, and, after healing, depressed scars are left. Treatment, therefore, should be directed toward as many components as possible in the pathogenetic chain.

First, one should evaluate the general health of the patient. Anemia, foci of infection, malnutrition, and constitutional diseases may well be aggravating factors. It is not an isolated incident to learn that a child with a severe acne made remarkable improvement after removal of badly infected tonsils. However, the disease often occurs in a person in good general health.

Dietary factors are important. Greasy and fatty foods tend to aggravate this disease and should be restricted. Particularly, the patient should avoid chocolate, nuts, peanut butter, potato chips, French fried potatoes, pretzels, pie, pastries, cookies, cake, and ice cream. Some therapists eliminate milk, but since a growing person needs milk it should not be restricted to less than 2 glasses a day. Sea foods, particularly shell fish, because of their iodine content, should be avoided, as also should iodized salt. Likewise, bromides aggravate acne and must be avoided.

Local therapy of acne is quite helpful. Frequent washing with soap and water is advisable, but the patient should be told that the dark color of the comedo is not due to dirt but to chemical change in the lipoid material in the pilosebaceous orifice. There are numerous preparations for local use in the form of lotions, creams, or cakes. Some of the more popular are Acnomel, Acnomel Cake, Sulfolac, Lotio Alsulfa, Intraderm Sulfur, Sulforcin Solution, and Sulforcin Cake. However, all depend chiefly upon sulfur for their main therapeutic advantage, and there is but little basis for choice among them. Lotio Alba is as effective as any other local remedy and is a lot cheaper than most of them.[2]

Surgery may often be beneficial. Blackheads may be expressed, and cysts and abscesses opened, but overzealousness may lead to unnecessary further scarring. Recently, sanding of acne scars has been introduced. In the hands of a capable operator and in carefully selected cases, it may be of value, but it entails the hazards of general anesthesia and there is always the danger of secondary infection. It is very expensive for the patient and is hardly to be considered a routine treatment. The results we have seen from this therapy have not been any better than some we have seen from the carbon dioxide slush therapy.

The local application of carbon dioxide slush enjoys a rather well-earned popularity among dermatologists today. It is made by mixing solid carbon dioxide with acetone, and usually sulfur precipitate is added to the mixture. It may be applied to the skin by means of a large cotton applicator once every 5 to 7 days. However, it must be applied carefully, since overdosage results in blistering and can even cause sloughing. It is best given by one who has been trained in its use. It is particularly effective in the younger acne patient with a lot of tiny lesions, and it is very helpful in flattening down the acne scars and rendering the pits less noticeable.

Ultraviolet light gives some benefit when given to the point of mild peeling, but the results are likely to be temporary. It may be combined with other forms of therapy and in the usual dosage is safe even when given over rather long periods of time.

Thyroid extract is often useful, but the patient should have a B.M.R. before thyroid is administered and the dosage should not be pushed to the point where the patient becomes nervous or jittery.

Estrogen therapy has been popularized by Andrews, Way and others.[3, 4] It should not be given routinely, but in females whose acne is characterized by premenstrual flare-ups and in whom simpler measures have not controlled the lesions, it may be indicated. One should begin with the smallest possible daily dosage and increase it only if necessary. Estrogen should be omitted during the menses and should not be given over too long a period of time. When it is stopped, it should be stopped gradually, since the sudden cessation may produce a menstrual flare. In my experience Premarin in dosage of 0.62 to 2.5 mg. has been the best tolerated estrogen.

Estrogen therapy is apparently of no value in the male. White and Lehman[5] reported that diethylstilbestrol given to males with acne did not give distinctive clinical improvement even though estrogenic effects including gynecomastia developed and the 17-ketosteroid excretion was diminished.

Local application of estrogen cream still is used by some, but the dosage absorbed is uncertain and it would appear that better effects result with systemic administration. Lunsford[6] reported 24 patients treated by the estrogen cream (1.2 mg. per Gm.) and found it to be useless.

Progesterone for females with acne was advocated by Way and Andrews,[3, 4] and Dennie in discussing their paper reported it helpful in males with cystic acne. However, Lewis[7] reported poor results from the use of progesterone. More experimental work is needed to complete the evaluation of hormonal therapy in acne.

Antibiotic therapy has been given with good results, especially when the infectious phase of acne is predominant. Frequently, it has been combined with estrogen therapy. The wide spectrum antibiotics are usually considered better than penicillin or the sulfonamide drugs. However, these antibiotics are extremely expensive, since the patient must take them for many weeks. Moreover, there is always the danger of intestinal moniliasis when such antibiotics are administered for long periods of time. Recently I have been impressed by good results from the use of erythromycin in acne, although its spectrum is not quite so wide; hence, I feel it may be a little safer to use.

Vitamin A in large dosage has been enthusiastically reported of value. However, we share the opinion of Mitchell and Butterworth,[8] who in a carefully controlled series of acne patients found it to be useless. Perhaps it may help a few patients, but it is not the treatment of choice.

Psychosomatic factors in acne are often important. The patient becomes sensitive about his or her appearance, has feelings of shame and frustration, and may withdraw from society. This tends to aggravate the disease, and the patient may seek solace in foods which aggravate the disease. Thus a vicious cycle is established and we must break it to effect a cure. It is not unusual to see a young girl pick or dig her face because of a maternal conflict. If the patient is seen early, good common-sense psychotherapy and encouragement by the family doctor may be curative.

X-ray therapy is probably not used as often as it was a few years ago but by no means has it been or should it be abandoned. The case is well stated by Combes and Costello,[9] who state, "Roentgen ray therapy is not the only treatment of the moderately severe and the severe types of acne, but it is the most effective method when other forms of therapy have been of no avail. It is frequently more effective in the hands of a competent dermatologist than all other methods combined."

In treating acne by X-rays one must not give more than 1,200 r to any one skin area, and, when the amount is less than 1,000 r, if the treatment should be given in fractional dosage, damaging sequelae do not result. There is a misconception that X-ray therapy causes the pits seen in healed acne patients. This is not so, since the pitting is due to tissue destruction by the disease. When the patient's face is covered by large cysts and papulopustules, the pits cannot be noticed, but when the pustules heal, no matter whether as a result of time or therapy, some pitting is bound to be left. In a review of a large number of follow-up cases, Sulzberger et al[10] were able to show that no radiation sequelae were to be found in cases of superficial X-ray therapy when the total dosage after fractional therapy was less than 1,000 r.

SUMMARY

Acne is a highly prevalent disease which should be treated early. It is hard to establish routine therapy for a disease that has so many factors in its causation. Each patient should be carefully evaluated from the standpoint of general health, foci of infection, and evidence of endocrine imbalance. As our knowledge of hormones increases, the last will probably take on more meaning. Local therapy is important but must not be overdone. The use of solid carbon dioxide slush and fractional doses of X-rays are valuable methods of definitive therapy. Our only hope is that the medical profession will advise parents and their children that the pimples of adolescence must not flourish and damage youth on the shameful basis of neglect.

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DIVERTICULITIS AS A SURGICAL ENTITY*

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TODAY the population of the United States is nearing the one hundred and fifty million mark. In the last 50 years the adult life expectancy has been increased nearly 17 years. Actuarial tables now reveal that an average adult should anticipate a lifetime of 67 years. Stated simply, this means that hundreds of thousands of men and women are advancing to those decades of life which subject them to specific diseases. One of these specific diseases is diverticulitis.

It has been estimated by one group of reliable investigators that at least 10 per cent of adults examined radiographically by means of the barium enema have diverticulosis.[1] Other estimates run slightly to considerably higher; indeed, one estimate runs as high as 20 per cent of all the adult population above 50 years of age. If this figure is acceptable, diverticulosis must be considered as one of the most common diseases of the gastrointestinal tract.

In this large group of people, 1 in 10 has diverticulitis, either clinically,[1] radiographically, or both. It is this group with diverticulitis that is the subject of this presentation.

Until recently the surgical literature on the subject has dealt almost entirely with the surgical management of the complications of diverticulitis. Among the complications most frequently encountered are: (1) acute perforation, (2) abscess formation, (3) obstruction, (4) situations in which the differential diagnosis between diverticulitis and neoplasm cannot be made, (5) fistula formation, (6) repeated hemorrhages, and (7) lack of relief of symptoms by conservative measures.

In reviewing the list of sequelae of this disease, it is apparent that the future holds the possibility of a variety of events for a patient saddled with the diagnosis of diverticulitis.

Diverticula occur anywhere within the large bowel with the exception of the rectum. The most frequent site is the sigmoid portion of the colon, and the second most frequent is the rest of the descending colon. It is in this relatively short segment of colon that the vast majority of complications occur. Diverticula are seen frequently in the transverse and ascending colon, but inflammatory changes in these areas are the exception rather than the rule.

There is no proven explanation as to why diverticulitis and its complications are limited essentially to the descending and sigmoid portions of the colon. The fecal stream in the ascending colon and transverse colon is relatively liquid, whereas it becomes increasingly solid as it progresses. Therefore, impaction of fecal matter is facilitated in the diverticula of the lower colon, leading to necrosis of the mucosa of the diverticula and abscess formation, granulomatous changes, and fibrosis.

Diverticular abscess is the most common complication of diverticulitis. It may run an acute course, resulting in perforation, and necessitating surgical drainage. The abscess may be adjacent to the bladder and perforate into this organ and produce a sigmoidovesical fistula. It may perforate into adjacent loops of bowel and form a variety of enterocolic fistulae.

Recurrent abscess formation may lead to a progressive fibrosis and produce partial or complete obstruction of the intestinal tract. This fibrosis may produce symptoms and radiographic signs that cannot be distinguished from annular carcinoma. Furthermore, recurrent attacks of diverticulitis may result in the production of granulation tissue within the diverticula that in time produces bleeding that may be as debilitating as chronic hemorrhage elsewhere in the gastrointestinal tract.

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* Read at the Regional Meeting of the Southeastern Surgical Congress in Washington, D. C., October 3, 1953.

Finally, the chronic inflammatory changes associated with long-standing disease may so alter the mucosal pattern as to make impossible the differentiation between this disease and ulcerating carcinoma of the colon.

A review of the literature reveals that the surgical approach to diverticulitis has been reserved primarily for the treatment of its complications when the complications arise. It is a well established principle that severe diverticular abscesses should be drained. The obstructive sequelae are usually treated in 3 stages, namely, decompressive colostomy; then in 2 to 6 months, an anterior resection with primary anastomosis; and finally, 4 to 8 weeks later, a closure of the colostomy.

The 3-stage approach had also been the procedure of choice for many years in dealing with obstructing malignant lesions of the left part of the colon. Anterior resection and primary anastomosis had been tried repeatedly during the first half of this century, only to be abandoned because of the high morbidity and excessive mortality incident to this approach. Intestinal intubation and potent intestinal antibiotics were not available. Fluid-replacement therapy was more empirical than physiologic.

Now the 3-stage procedure is rejected as an elective method, and 1-stage resection and anastomosis is the rule for neoplastic disease, except in those cases in which abdominoperineal resection is indicated. With adequate and intelligent preoperative management, the surgeon today feels free to perform open anastomosis of the colon, confident that his over-all mortality will run no higher than that of surgery of the gallbladder.

It seems that a reëvaluation of our treatment of diverticulitis is needed. We have all sympathized with the patient that has undergone 3 operations for a single disease, particularly since it burdens him with an objectionable, and sometimes unmanageable, colostomy for 6 months at a time. The financial outlay to the patient is considerable, and the loss of several months of earning power between operative stages adds to his financial and emotional strain. The problem is a growing one, in that our population is gradually shifting toward an average age group in which diverticulosis is prevalent. This age shift can be attributed to the advances in all phases of medicine in the past half century, but, in turn, it presents us with an increasing number of patients with disease of the latter decades of life.

The attitude may be taken that chronic and recurrent diverticulitis are diseases amenable to surgical treatment by 1-stage operation. In this category, one would consider the following groups:

1. Patients who do not respond to medical management, and who have radiographic evidence of diverticulitis over a relatively short segment of bowel.
2. Those who have had repeated febrile episodes with pain referable to the involved portion of the colon and radiographic proof of disease.
3. Patients who are intermittently obstructed or who are gradually acquiring an obstruction that threatens to become complete.
4. Patients in whom the differential diagnosis between diverticulitis and malignant disease cannot be made.

In conclusion, it appears that the surgery of diverticulitis has been overshadowed somewhat by the advances in 1-stage surgery for malignant disease. The same advances that have made primary colon resection for cancer a safe procedure are applicable equally to diverticulitis. One-stage resection in diverticulitis is safe; it achieves results, and finally it eliminates multiple procedures, months of colostomy life, and prolonged hospitalization with its attendant expense.

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OVERCONCERN WITH HEALTH*

Somatic and Physiologic Preoccupation: Hypochondriasis

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Clinical Features

IN TRUE hypochondriasis the patient usually insists either implicitly or explicitly on the presence of organic disease as the source of his complaints. His attention is abnormally focused on his subjective feelings or upon some aspect of function or health. This over-attentiveness may develop with an increased awareness of what were formerly sensations that failed to reach the threshold of awareness. In this fashion the patient may become acutely aware of minor variations in function and devote abnormal attention in this direction. In the broadest sense, concern about illness is "hypochondriacal" when it is out of keeping with the actual organic and functional pathology present. In contrast, patients with severe illnesses, when concern might be more warranted, may have relatively little preoccupation or apparent concern. An illustration of the latter was recently reported to me in which a physician was discovered to have inoperable cancer. His life and activities reflected little change. He seldom spoke of the cancer, although he did not avoid it, carried on in his usual efficient manner with his professional work, and developed a new hobby.

We regard undue interest in oneself as significant from a psychopathologic standpoint when competent, objective judgment indicates that the individual's effectiveness and efficiency in living are impaired and his attainment of satisfactions or happiness diminished. The overt presence of anxiety is apt to be less in cases of hypochondriasis than in other neurotic illnesses because the complaints themselves are an unconscious way of dealing with anxiety.[15]

This type of problem in emotional illness is not uncommon. Some hypochondriacal complaints are witnessed in company with many psychoneurotic illnesses. Mild hypochondriacs may persist in their preoccupations for years with little change. Occasionally, however, the movement into an hypochondriacal retreat is progressive and becomes increasingly absorbing of the patient's interest and attention. His libido is withdrawn from the outside world to become attached to symptoms within himself. Multiple symptoms are presented with an apparent or completely hidden (and usually denied) relationship to emotional disturbances. These symptoms may refer to any or every system, organ, and body function. In view of the ubiquity of manifestations, an attempt to list or catalog the hypochondriac's complaints or symptoms as such would run the gamut of medical clinical experience.

According to Bleuler,[16] "The picture of the condition of hypochondria consists in continuous attention to one's own state of health with the tendency to ascribe a disease to oneself from (objectively) insignificant signs. . . ." Cobb[17] reserved the term hypochondriasis to describe "a group of introverted patients whose main interest in life seems to revolve about their viscera. . . . The true hypochondriac is convinced that certain organs are diseased or are functioning improperly. It is impossible to convince him (otherwise) by medical examinations and argument. . . ."

I have earlier noted one typical clinical feature of hypochondriasis to be the discrepancy between the subjective anxiety about health and the objectively evaluated state of health. The level of concern with health of course does not necessarily bear any relation to the level of organic or functional pathology present. It is clear that the patient may often suffer serious discomfort in the complete absence of any demonstrable malfunction. The basis of emotionally determined visceral pain can occur via several psychologic pathways. First, stomach discomfort or pain, for instance, may be clearly "hypochondriacal," with medical studies entirely negative. Second, stomach pain may also be on a "conversion basis," with demonstrable malfunction in hypermotility, or as illustrated in hysterical vomiting. Finally, stomach pain, as with an ulcer, can result as a prolonged "chronic psychophysiologic response" to emotional stress. The latter situation is also sometimes called a vegetative or autonomic neurosis, a psychosomatic disorder, and occasionally an "organ neurosis."

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* This paper, the sixth article in a series by Dr. Laughlin covering the psychoneuroses, is being published in two parts, of which this is Part II. The next article in the series, entitled "The Obsessive Personality," will appear in the April issue of the Medical Annals.

The location for a hypochondriacal symptom can be in any organ or any region of the body. No part of the body is immune. Symptoms may likewise run the gamut of subjective experience. They may simulate almost any organic illness, may be single or multiple, credible or bizarre, persistent or shifting.

Overconcern with health may sometimes be initiated by the threat and stress incident to serious injury, illness or surgery. The following briefly cited example illustrates the onset of a hypochondriacal focusing of attention following successful surgical portacaval anastomosis in a case of Laennec's cirrhosis.

Case 9. A 37-year-old machinist was hospitalized for diagnostic study following several episodes of hematemesis. This proved to come from intermittent hemorrhage from esophageal varices resulting from the venous stasis of moderately advanced Laennec's cirrhosis. To ameliorate the dangerous venous back pressure, surgical anastomosis of the portal vein to the vena cava was successfully undertaken. Preoperative portal pressure of 320 mm. of water dropped to 130 mm. immediately following the procedure (normal pressure is 90–140).

Following the operation the patient became irritable and anxious. Although his physical recovery from the surgery was uneventful, he had more complaints and symptoms after the operation than before. He was increasingly concerned about pains in his legs and abdomen and about digestion and elimination. He had trouble sleeping and eating and reported a series of nightmares. Gradually he focused such an amount of attention upon his state of health that he was soon as effectively handicapped and restricted from an emotional standpoint as he had been from the cirrhosis. Although the surgery was eminently successful, his emotional response to it in effect defeated the medical efforts to help him.

Undoubtedly advancing age with loss of vitality and elasticity helps to increase the vulnerability to hypochondriacal preoccupation in many instances. As goals in life are not achieved and external sources of satisfaction fail, we can expect and we find instances of increasing concern with health around the time of the climacteric and as the senium approaches. Occasionally the untoward emotional responses to certain drugs may include elements of hypochondriasis, although other responses are much more frequent, i.e., anxiety, restlessness, irritability, nervousness, insomnia, and even disorientation and temporary psychotic states. Such commonly used drugs as pyribenzamine, scopolamine, cortisone, the amphetamine group, and the barbiturates are among the most frequent ones which can produce these unexpected or unwelcome emotional responses.

The physician must be aware of the very serious implications in certain cases of overconcern with health. Hypochondriacal preoccupation may have a sinister portent in its occasional ushering in of a malignant form of emotional disorder as illustrated in the following case of schizophrenia.

Case 10. A single, 26-year-old textile designer met a girl while attending a movie and they kissed. He began to worry the next day when his tongue seemed swollen and he began to fear he had contracted some form of venereal disease. Shortly thereafter he noted a very minor skin rash which tended to convince him that he was suffering from syphilis. As he became more and more preoccupied with these concerns things seemed increasingly unreal to him (depersonalization), he had trouble at work, lost interest in events, and spent more and more time alone.

His vision seemed distorted, and he developed a fear of death. There was an increasing preoccupation with somatic affairs and a retreat into fantasy. Outward emotional display first became decreased and then inappropriate. He began hearing a voice which accused him of having syphilis and being guilty of great sin. In greatly abbreviated form this illustrates the onset of an acute schizophrenic episode with a rapid progression from original hypochondriacal concerns into an advanced psychotic state.

Differential Diagnosis

In view of the appearance of hypochondriacal trends in association with many physical and emotional conditions the diagnostic problem is basically one of diagnosing the underlying condition. Hypochondriasis may be seen as part of almost any of the neuroses or psychoses. Among these, it is most frequently seen as a manifestation in the fatigue states and neurasthenia, in depression, and in the anxiety reactions. Concern with health can become obsessive or be severe enough to constitute a "compulsion" so that certain cases of obsessive-compulsive states may offer difficulties in differential diagnosis.

With increasing experience and professional sagacity the physician will be able in many cases to make a positive diagnosis of the source of difficulty as emotional. Over-examination, uncertainty, or constant searching for obscure possible physical explanations can "play into" the neurotic needs which the patient is attempting to meet via this nonconstructive pathway. Although this may superficially please the patient, it can also do him great harm. On the other hand, a cursory examination and prejudgment can also cause trouble and be most embarrassing as in the case of a patient recently reported to me who was sent for psychiatric consultation because of preoccupation with rectal function and bleeding. The patient had good cause to be preoccupied in view of the presence of multiple friable bleeding polyps which were revealed upon requested later sigmoidoscopic examination. This was not hypochondriasis.

The clinician must also bear clearly in mind that the presence of clearly established organic disease does not rule out the simultaneous presence of emotional disturbance, nor does it necessarily account for all the patient's symptoms, some of which may also have an emotional origin. The onset of preoccupation with health following or accompanying organic conditions is largely determined by the person's relative ability to handle the threat of the illness and his individual response to his position of relative helplessness. Earlier a brief differentiation was made between emotionally-based somatic complaints according to different psychologic pathways of initiation. Cobb[18] reported that "it is difficult and often impossible to tell hypochondriacal neurosis from early schizoid or affective psychosis."

In case 10 the onset of schizophrenia was marked by hypochondriasis. When a hypochondriacal defense mechanism breaks down, a psychosis may ensue.[14] Hypochondriacal preoccupation is seen in schizophrenia,[7, 9] psychotic depressions,[7] including involutional melancholia,[6, 14] paranoid conditions,[4, 5, 19] the senile and arteriosclerotic psychoses,[16] and paresis.[16, 19] In these grave mental disorders the hypochondriacal concern may be seen to reach its ultimate development in the most deep-seated somatic delusions.

Treatment

Difficulties with the patient unduly concerned over health relate first to the recognition of the emotional basis of the difficulties and second to problems of management. Skill in these areas often relates to the existing attitudes which the physician may have developed toward these types of emotional problems. Patients of course cannot be talked out of their anxiety. They may respond only temporarily, if at all, to reassurance, while attempts at persuasion or the seemingly rational approach of offering opinion and medical proof often will prove frustratingly futile. As noted earlier, patients who manifest hypochondriasis are sometimes erroneously regarded as malingerers. Family, friends, the public, and physicians too have been known to speak of them disrespectfully as though they were somehow consciously responsible for their excessive preoccupation with health. It is, of course, correct that the true hypochondriac is possessed of no etiologic organic pathology. Nevertheless, the symptoms, the discomforts described, and the patient's concern and discomfort are very real matters to him. Indeed, these psychogenic complaints may well be more real, more disabling, and more disturbing to the patient than an actual organic disorder.[14]

The physician should constantly ask himself speculative questions as to the hidden source of anxiety, the defensive purposes, and the underlying desperate psychologic needs which enter into preoccupation with health. Although this may not help much in a reliable solution of the psychopathology, such a dynamically oriented approach can help dissipate the frustration and helplessness of the physician. It is eminently more constructive in so far as the patient is concerned. Also, when the physician has some recognition of the hidden emotional origins of hypochondriacal symptoms, it is hardly possible for him to retain much prejudice.

Adequate medical handling of the hypochondriac is a therapeutic challenge. Certain patients will respond sufficiently to simple reassurance and do not necessarily require psychiatric evaluation or treatment. Psychiatric consultation and possibly psychotherapy are indicated:

1. When hypochondriacal preoccupation is moderate or severe.

2. When the discrepancy between concern and possible organic basis is large.

3. When the degree of somatic preoccupation is progressive.

4. When the hypochondriacal trends are suspected of initiating or accompanying a more malignant psychiatric disorder, or when hypochondriasis as a defense appears to be breaking down.

5. In cases in which the hypochondriacal preoccupation is constrictive, interferes with efficiency, or prevents the serving of reasonable satisfactions in living.

The psychotherapy of choice is investigative and insight-seeking. It is not easy to secure genuine constructive change when this mechanism is well established. If it is serving as an effective psychologic defense, patients will not surrender this defense easily, nor until other more healthful patterns appear clearly advantageous. The very development of hypochondriacal symptoms is an implied statement of preference, albeit unconscious, by the patient for troubling "painful" physical complaints as opposed to an awareness of painful emotional conflicts. Recognition of this helps us understand some of the severe difficulties which are inherent in the management and the treatment of these patients.

Another difficulty sometimes encountered in intensive psychotherapy is the lay tendency in some quarters to regard introspection per se as unhealthy. To many lay people introspection is almost automatically equated with self-centeredness, narcissism, self-love, or hypochondriacal preoccupation, or with the danger of their development. This equation is understandable in view of the inherent recognition by the public of the emotionally unhealthy possibilities in overconcern with self. This has led to such well-intended but often superficial lay admonitions as "forget yourself," "stop thinking so much about yourself," "you need outside interests," etc. One must keep in mind the very important fact that introspection and self-study can, under proper direction, be constructive, profitable and healthful. The psychotherapist works in a mutually collaborative endeavor with his patient to learn what makes him function, what emotions are present, how they developed, and what makes him "tick" as a person. The process is one in which constructive introspective study is a basic essential. Intensive psychotherapy is literally a postgraduate course of study in oneself.

For real resolution of hypochondriacal trends, the basic mechanisms must become apparent to both patient and physician. Prior to referral for psychotherapy the interaction of emotional and physical processes can be illustrated to the patient with simple examples. Most patients can understand the effect of fear upon heart rate and respiration, and the effect of other emotions upon such things as appetite, perspiration, urgency, blushing and nervousness. It may then be indicated in some instances and possible to point out to the patient some possible emotional factors in fatigue, insomnia, headache, digestive function and other areas. English[20] has written an excellent brief and simply worded aid to physicians in the explanation to their patient of psychophysiologic relationships. This article can be consulted for more and detailed suggestions.

Fenichel[11] equates the prognosis in treatment in inverse proportion to the amount of narcissism present. He points out the vital requirement for (1) the capacity to develop transference, and (2) the (developmental) status of the infantile genitality. A determination of the adequacy of these necessary foundations to analytic treatment can only be made by a trial analysis. Fromm-Reichmann[21] has cautioned against the inadvertent encouragement by the therapist of hypochondriacal preoccupation by an inquiry about complaints at the beginning of a treatment session. This author also points out the disadvantages inherent to succumbing to the demands made by some hypochondriacs for repeated physical examinations because of the danger in this condition of "a serious disruption of the patient's interest in overt interpersonal relationships . . . (and) the danger of the patient's retreat into somatic self-engulfment."

Considerable patience is a "must" in the therapist. Dynamic factors in the patient's personality development must be uncovered and a program of reëducation instituted. Reorientation of his emotional drives and a more healthy emotional maturation will leave the patient free of his need for the hypochondriacal reaction pattern. In essence, the patient must be offered a more constructive way of life to take the place of the neurotic "solution" already a part of his life. A psychoanalytic régime may well take several years, depending on the relative speed of progress, the value of the work, the patient's malleability, and the strength of his needs to cling to neurotic emotional patterns.

Thus, the patient must be helped to develop a constructive outgoing interest in himself. His introspection has been very nonconstructive. Treatment aims to uncover the relationships between his symptoms and his emotions. The very nature of hypochondriasis is indicative of the patient's resistance to a clarification of these relationships.

It is my earnest hope to help make some of the basic data concerning the current knowledge of psychiatry more available to the general medical profession. In this series I am attempting to correlate clinical and descriptive psychiatry with the more generally accepted dynamic concepts of psychoanalysis and with current trends in nomenclature. This is an era of rapidly expanding knowledge of human motivation. There is increasing recognition of the powerful influences upon us of forces which are outside of conscious awareness. Accordingly, I believe that every physician has some responsibility to keep himself informed to some extent as to modern developments in the field of psychiatry and psychodynamics even as the roentgenologist, pathologist, and psychiatrist keep informed of the major new developments in antibiotics. This will also obviate the occurrence of such embarrassing incidents as one in which a physician with considerable training and experience recently made the flat assertion that the etiology of depression was infectious.

SUMMARY

Persistent overconcern with the state of health is called hypochondriasis. This is a common problem in most medical practice. It is charac-

teristically marked by a gap between the subjective feelings and concern of the patient and the objective evidence of responsible organic pathology. Hypochondriasis is seen in conjunction with organic illness and with many kinds of emotional illness. Organic findings may be considerable, unusual or absent, but do not realistically account for the patient's discomfort and concern about them. Hypochondriacal trends may be present in certain stages of personality development when they are not necessarily of pathologic significance.

Patterns of overconcern with health have their original beginnings in early childhood with inadvertent contributions sometimes traceable to parental attitudes. Later adult hypochondriasis can be thought of as areas of arrested development of maturity (fixation), regression to earlier patterns of reaction, or both. The internal basis for hypochondriacal preoccupation stems from deep-seated psychologic needs which are outside of the patient's conscious awareness. These were classified as the primary needs in which were included:

1. Aiding the concealment and denial of rejected wishes, primarily aggressive, sometimes sexual ones (the reënforcement of their repression).
2. The channeling of anxiety away from deep-seated emotional conflicts into bodily areas (absorption and diversion of psychic energy).
3. Punishment for real, or subjectively so judged (largely outside of awareness) evil acts or wishes (unconscious retribution).

Under secondary gains were included:

1. Largely unconsciously sought effects upon people, the seeking of sympathy, attention and love.
2. The seeking of a more dependent position in living; the regressive retreat to a less active, less responsible level, as was present in early life.
3. The escape from an intolerable situation.

The clinical features were discussed briefly and the distinctions noted between visceral complaints on the basis of hysterical, hypochondriacal and psychophysiologic mechanisms. Mention was made of hypochondriasis in relation to the climacteric, following surgery, and its occasional role in ushering in an acute schizophrenia. Hypochondriasis is seen particularly in association with neurasthenia, depression, and the anxiety reaction. It is seen in certain psychotic states, in which it may reach its most malignant form in deeply rooted somatic delusions.

A few comments were offered about treatment, including the indications for psychiatric referral. In good medical handling there should be an original thorough examination with findings positively presented and an avoidance of repeated later examinations. Certain points were selected for illustration by clinical examples.

Acknowledgment is made to Dr. Hewitt I. Varney and to Dr. Daniel S. Jaffe for review of the manuscript and to the latter for case 6. Acknowledgment is also made to Dr. Marshall deG. Ruffin, who collaborated in the preparation of the chapter on Hypochondriasis in "An Outline of Dynamic Psychiatry," from which certain ideas have been derived, modified, and expanded.

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(*Continued on page 186*)

President's Page

THE PHYSICIAN AND THE RESERVES

WITH THE COMING TERMINATION OF THE "DOCTOR DRAFT" ON JUNE 30, 1955, AND WITH THE LIKELIHOOD THAT VERY FEW, IF ANY, PHYSICIANS WILL BE DRAFTED FOR THE ARMED FORCES BEFORE THAT DATE, RENEWED ATTENTION IS FOCUSED UPON THE RESPONSIBILITY OF THE MEDICAL PROFESSION TOWARD THE ARMED FORCES AND IN PARTICULAR TOWARD THE MEDICAL RESERVES.

COINCIDENTALLY, IT IS OBSERVED WITH SATISFACTION THAT DR. FRANK E. WILSON, DIRECTOR OF THE AMA WASHINGTON OFFICE, HAS JUST BEEN PROMOTED TO BRIGADIER GENERAL, MEDICAL CORPS, UNITED STATES ARMY RESERVE, IN COMMAND OF THE 805TH HOSPITAL CENTER.*

A LET-DOWN IN THE FEELING OF PERSONAL RESPONSIBILITY INEVITABLY ACCOMPANIED THE DOCTOR DRAFT. BUT NOW SURGEON GENERAL GEORGE E. ARMSTRONG AND COLONEL JAMES B. MASON SAY: "THE FAILURE . . . TO RECOGNIZE THEIR RESERVE OBLIGATION OR TO PARTICIPATE IN AN ACTIVE CAPACITY CONSTITUTES A THREAT TO NATIONAL SECURITY AND AN AVOIDANCE OF PERSONAL RESPONSIBILITY THAT IS FRIGHTENING." THEIR STORY CLOSES WITH THIS: "IT'S YOUR ARMY! IT'S YOUR COUNTRY!"[1]

THE MEDICAL PROFESSION HAS NEVER FAILED THE COUNTRY IN PREPAREDNESS AND IN PARTICIPATION. PLEASE GOD IT WILL NOT NOW AT THIS TIME OF GREATEST THREAT TO OUR NATIONAL SAFETY.

Herbert P. Ramsey

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* Further information relating to the reserve components of the Army, Navy and Air Force is found in the news columns of this issue.

[1] ARMSTRONG, G. E., AND MASON, J. B.: Physician's stake in the Army Reserve program. J.A.M.A., 1954, **154**, 578 (February 13).

Editorials

TEACHING WITH PRIVATE PATIENTS

As the indigent patient disappears from the American hospital scene organized medicine must find and adopt means for carrying on its teaching program with private patients.

The need for constant and continuous teaching is almost as well recognized by the lay patient as by the profession itself. The willingness and even preference for some of our large clinics by well-to-do patients is evidence of this fact. The general satisfaction with this aspect of care in armed service and veterans hospitals has the same significance.

Many thoughtful people believe that economic segregation is discriminatory and certainly bad. The effort of most city hospitals to look like private hospitals to their patients is part of the effort to avoid the stigma of indigence. Individual physicians have always professed to believe that good care should not depend on financial means. Indeed, the noblest aims of the profession have been met on this exact point. However, there is a popular feeling that indigent patients have not infrequently been subjected to certain indignities in the name of teaching. Whether this is true or not, many private patients have been frightened by tales of exposure to a long line of clumsy examiners and have been almost more concerned to buy privacy than competent treatment.

It may be concluded logically that if a young physician is in training to take up a private practice, there are certain things to be had only by dealing with private patients. It has frequently been noted that residents from teaching services utilizing indigent patient wards have actually had to go back and learn some of the requirements of kindness and courtesy before taking on successful private practice. How much better it would have been for the art of medicine to have been developed along with its science!

It is becoming commonplace to bemoan the loss of teaching services which are still confused in common thought with indigence. It has been thoughtlessly suggested by not a few that Blue Cross-Blue Shield patients may properly be used for teaching instead of "private patients." This confused view possibly stems from the belief that those who voluntarily embrace insurance coverage are receptive to regimentation. The number in this group, however, is becoming great enough that such an attitude must be corrected. As a matter of fact, many who have such coverage feel that they, more than ever, have satisfied the traditional requirement of the private patient to pay his own way.

Again, the mounting costs of hospitalization are making it more important for a private hospital to receive from every patient, directly or indirectly, income which pays most of his way. And, those in the private rooms are no longer able to pay a rate which is sufficient to carry ward beds on a free or even a very cheap basis.

Thus it seems certain that the apparent reduction in ward beds and outpatient clinics is real and is based on progressive changes. One may be sure that if the new Government proposals do anything at all in this field, they will result in further reduction in the number of indigent patients. These developments may well result in city hospitals as now commonly organized becoming outmoded institutions.

Organized medicine is faced with the urgent

Opinions expressed in contributions in the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia.

need to modify traditional teaching forms so that private and voluntary hospitals are not working at a disadvantage. This rather specifically involves accreditation programs. There is a present tendency for heavy concentration of American graduates in a limited portion of the whole hospital group. Many private and voluntary hospitals with fine attending staffs and all facilities for good teaching are functioning with makeshift house staffs. This creates a vicious cycle because no hospital can build a good teaching program, especially with private patients, without a fine supporting house staff. It would seem to be a problem for medical statesmanship to find some solution for this dilemma. Certainly means must be found to train many more of our American medical school graduates with private patients or we will find that the new generation does not know the old.

D. S.

DOCTOR, HAVE YOU HAD YOUR CHEST X-RAYED RECENTLY?

Tuberculosis is responsible for more deaths in the United States than all other infectious diseases combined.

Tuberculosis leads all diseases as the cause of death in the most important years of our country's young people—the 15 to 35-year age groups.

In recent surveys the greatest number of new case findings were in the 55 to 65-year age group.

No, contrary to the thoughts of many of our patients, and also some of our physicians, tuberculosis is far from extinct.

You, as a physician, practicing medicine or surgery, obstetrics, or any of the subspecialties, owe it to yourself, your family, and your patients to have your chest X-rayed once yearly if under 40 years of age, and twice yearly if over the age of 40. Likewise, I believe that what is good for your health is most certainly excellent for your patients. We physicians, like the minister, must practice what we preach.

It is up to us to convince our patients, all of them, that the prevention, detection, and the cure of tuberculosis are possible if we begin a whole-hearted, concentrated effort on this score now.

Beginning in March, 1954 the District of Columbia Tuberculosis Association, under the guidance of its Advisory Committee on Adult Health Education, working with the D. C. Department of Public Health, will begin an educational campaign among the citizens of the District of Columbia for the purpose of new case-finding as the first step toward prevention of tuberculosis. We hope to accomplish this by newspaper, radio and television publicity. Along with this, the mobile unit for chest X-rays will be stationed at strategic spots in the District of Columbia for service to the public. But this is not enough. There are certain segments of the population not attracted by any campaign, especially one about tuberculosis. Here, in the 4- to 15-year and the 45- to 65-year age groups, it is up to us physicians (nurses and social workers also) to contact all persons possible and to impress them with the importance of the chest X-ray.

We physicians know that the chest X-ray is one of the most important, if not the most important, single laboratory procedure. Just think about this. There is no other single laboratory procedure in the practice of medicine or surgery today that will reveal so many diseases, in so little time, with so little expense, and so little discomfort or disturbance to the patient, as the taking of a chest X-ray.

The list of diseases uncovered by the roentgenogram is limited only by our inability to remember everything. It may show tuberculous lesions, enlarged hilar nodes, areas of pulmonary consolidation, cavities, and cysts. We may find the lesions of primary or secondary malignancy, the nodules of silicosis, lipid pneumonitis, or atypical pneumonias; likewise, miliary tuberculosis, fungus infections, sarcoidosis, ad infinitum. The list is long. God grant that our memories of what can go on in the thoracic cage be likewise.

We of the Advisory Committee on Adult Health Education of the District of Columbia Tuberculosis Association would like to enlist each and every physician as a member-at-large of this committee, irrespective of the type of medical or surgical practice in which he is engaged, to aid us in this new year, and particularly during our educational campaign beginning in March 1954.

If you will begin with yourself and your family and have your X-rays done now, then see to it that each and every patient visiting you or seen by you at home or at the hospital receives a chest X-ray, a good job will be done by all.

Doctor, have you had your chest X-rayed recently?

I. Phillips Frohman, M.D.
Member, Advisory Committee, Adult Health Education, District of Columbia Tuberculosis Association

THE VISITING NURSE ASSOCIATION

"I am so glad we found out about you," said Mr. Brown, now ill at home. A Visiting Nurse qualified to give skilled nursing on a part-time basis and able to carry out the physician's orders was just what he wanted. The recent change in our name from The Instructive Visiting Nurse Society to The Visiting Nurse Association will make it easier for everyone to understand our services. The term "Instructive" was often confusing. Of course, a Visiting Nurse always teaches a member of the family how to give nursing care between her visits and how to administer medication and treatment when the physician in charge believes a member of the family can be taught to assume this responsibility. Teaching will continue to be a part of every visit to meet the family's needs and as ordered by the physician. Helping a family live with an illness is a contribution the Visiting Nurse makes at a time when long-term illnesses have increased. Nursing care, treatment and counseling are important in the progress of the patient and in maintaining family living when progress is impossible.

Visiting Nurse associations are increasing in number to aid physicians in the care of many of their patients at home. Recently this organization has extended its nursing services to include nearby Maryland whenever provision is made for payment for these calls. For those physicians who may not know they can call a Visiting Nurse and for those who have not called for a long time, we offer this brief information.

Following discharge of patients from the hospital, Visiting Nurses may be called to re-dress surgical wounds or to continue with hypodermic medications. In some instances a nurse may visit twice daily, to give a special treatment or when a person is seriously ill. Frequently a nurse can teach a member of the family an easier way to care for a patient who may be ill a long time. She can teach the patient how he can help himself and in this way lessen the strain on the family. She can show the family how to supervise the patient's posture in bed in order to prevent contractures and disuse disabilities and how to get a person out of bed, and she can teach ambulation technic as the doctor advises it.

Because the Visiting Nurse Association now has a nurse physical therapist consultant, our nurses, under her guidance, as directed by the physician, aid patients who have suffered cerebral accidents in recovering from disabilities and in making maximum use of unaffected muscles. Arthritis nursing may include hot packs and exercises. Patients sent home in a cast may have care and treatment at home until they are able to go to a physical therapy center. Sometimes a patient needs a few lessons in crutch walking in order to overcome the fear which keeps her in bed.

Patients are often more fearful than they admit when they return to their own homes. This is frequently true when a young mother has her first baby. The Visiting Nurse can bathe the baby while the mother watches and asks the questions she thinks are too silly to take up with the doctor or which she forgot to ask during the last examination. The nurse can be with the mother the first time she bathes the baby at home. The assurance which the nurse gives the mother helps to establish a happy mother-baby relationship free from unnecessary anxiety. In our experience, it takes only two or three visits for a mother to develop confidence in her own ability.

Occasionally, a patient being cared for by a practical nurse requires a treatment which the practical nurse is not prepared to give. We have on our staff 53 graduate registered nurses who have had additional preparation in public health nursing. Therefore, the Visiting Nurse may be called for and is qualified to give special treatment. Then, too, she is sometimes asked to supervise and assist with care when there are complications for which her skills are needed.

These services are available to all who are under the care of a physician at the cost of $2.50 for a visit under an hour; 50 cents additional is charged for each quarter of an hour. An adjustment is made for those unable to pay the full cost because the Visiting Nurse Association receives allotments from the American Cancer Society toward free nursing care for cancer patients and from the Community Chest Federation for all types of nursing at home.

CLARISSA GIBSON, R.N.
Executive Director,
The Visiting Nurse Association

HELP FOR RETARDED CHILDREN

The reader's attention is called to the section on Correspondence in this issue, with particular reference to the comments of Dr. John A. Lewis. Dr. Lewis is a member of the Board of Directors of a local organization called Help for Retarded Children. The information supplied in his letter is the specific type of knowledge that has been so hard to obtain in the past. For those physicians in practice who are called upon many times to supply advice and help for the families of retarded children, the information will be most helpful. This organization welcomes the help of interested physicians, and such coöperation could do much to further the "grass roots" solution to this most pressing problem. As was pointed out in a previous editorial,[1] the social and medical implications of a retarded child involves probably some two and one-half million families in the United States, surpassing, in mere numbers, almost any other unsolved challenge to pediatrics.

It would be well if each practicing physician, who has undoubtedly met this situation in the past, would jot down the telephone number referred to by Dr. Lewis. He will thus have at hand a source of information and help when confronted with distressed parents in this pitiful situation.

F. G. B.

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[1] M. Ann. District of Columbia, 1953, 22, 673.

In and Out of Focus

BY THE OBSERVER

Eisenhower's Health Program

As expected, President Eisenhower's health message contained few surprises. Disappointing to many was the paucity of details. However, legislation is now in the process of being written which will clarify the intentions of the Administration.

In medical circles interest centered largely in the health insurance proposals, for it was in this area that differences might arise. The American Medical Association, ever watchful for any indication of Government control by means of subsidy, either direct or indirect, gave its approval to this part of the President's program, with reservations.

In his message, the President endeavored to reassure the medical profession when he said:

> "We must . . . take further action on the problems of distribution of medical facilities and the costs of medical care, but we must be careful and farsighted in the action that we take. Freedom, consent, and individual responsibility are fundamental to our system.
>
> "In the field of medical care, this means that the traditional relationship of the physician and patient, and the right of the individual to elect freely the manner of his care in illness, must be preserved.
>
> "In adhering to this principle, and rejecting the socialization of medicine, we can still confidently commit ourselves to certain national health goals.
>
> "One such goal is that the means for achieving good health should be accessible to all. A person's location, occupation, age, race, creed, or financial status should not bar him from enjoying this access."

Emphasized by the President was the rapid growth of private and industrial health plans. This progress, he said, was evidence that these plans could reach many more people and provide better and broader benefits.

> "The Government need not and should not go into the insurance business to furnish the protection which private and nonprofit organizations do not now provide. But the Government can and should work with them to study and devise better insurance protection to meet the public need.
>
> "I recommend the establishment of a limited Federal Reinsurance Service to encourage private and nonprofit health insurance organizations to offer broader health protection to more families. This service would reinsure the special additional risks involved in such broader protection. It can be launched with a capital fund of $25,000,000 provided by the Government, to be retired from reinsurance fees."

Details of the reinsurance program will not be revealed until legislation implementing the health program has been introduced in Congress.

Editorial comment appearing in Washington newspapers was, with one exception, favorable. Indicative of the views held by these newspapers are the following excerpts:

> "President Eisenhower has placed before Congress a relatively modest starting program for improving the Nation's health. But modest as it is—in the sense that its recommendations are not so ambitious as those contained in the impressive Magnuson report of 1952—it is nonetheless a program that promises to accomplish a lot of good. And it has the added virtue, from the standpoint of practical politics, of being conservative enough to be safe from serious attack by either the economy-minded or the foes of 'socialized medicine'."—*The Evening Star*, January 19.
>
> "President Eisenhower's health program is a forward-looking but very modest attempt to bring better medical care to more Americans. It centers its efforts on aiding private health insurance plans and on helping states and communities to improve rehabilitation and hospital facilities. Only by a semantic distortion could this be construed as socialized medicine. Indeed, the most justified criticism will be that the program is not bold enough. It makes no apparent provision to improve care of the medically indigent—the persons who cannot pay for health insurance—and many of its recommendations are so general that they cannot be fully appraised until budget figures are disclosed."—*The Washington Post*, January 19.
>
> "The message disavows belief in socialized medicine, emphasizes the progress that has been made in prepayment of insurance plans to cover hospital and doctor

> bills, reasserts the sound proposition that the best medical care will result from the patient having free choice of his doctor—and then offers some proposals that would put the foot of socialized medicine in the Nation's door. . . . It is reasonable to suspect that the scheme masks a subsidy."
> —*Times-Herald*, January 20.
>
> "The medical insurance systems we have, with all due credit to them, are not adequate. Except perhaps for a few new ones, they simply do not offer protection against the enormous cost of a long illness or prolonged disability. A patient's benefits too often expire just when he needs them the most.
>
> "President Eisenhower's message to Congress suggests a way Government can help remedy this situation, without going into the health insurance business directly."
> —*The Washington Daily News*, January 19.

Washington commentators, too, had some views on the subject. Gould Lincoln, writing in *The Evening Star* for January 19, said:

> "Here are proposals, definite and realistic, with which only the most hard-boiled advocate of socialized medicine could take exception, and then only because these proposals if carried into effect will be an effective block in the path of the supporters of free medical treatment or medical treatment wholly under control of the Federal Government. . . .
>
> "Here, indeed, is a program that members of Congress, no matter what their political affiliation, can afford to support. Failure of support would be a black eye, not to the program, but to the Congressmen who deny support."

Radio commentator Eric Sevareid observed in a broadcast over the CBS network on January 19:

> "My knowledge of medical economics is not without its limits; but as a professional watcher of the political birds, it is perhaps not amiss for me to hazard the speculation that something is going to be done and fairly soon. The President sent up his own plan to Congress yesterday; the first impression of Congressional observers is that this plan or something like it will get somewhere this time."

There are a considerable number of physicians who are deeply disturbed by the antipathy to the American Medical Association in many quarters where it should have friends. The criticism most frequently leveled at the Association is that it opposes any medical care program not emanating from Dearborn Street. Usually the critic concludes his observations with the statement that the AMA is a decidedly negative force and somehow must be dealt with in the public interest.

Nothing would deflate these critics—and let's not minimize their number or their influence—more quickly than the AMA's wholehearted support of the President's health program.

Differences will undoubtedly have to be ironed out in order to make the program acceptable to everyone concerned; however, it is hoped that an agreement will be assiduously sought by the AMA so that it can give the President's health proposals its unequivocal support.

* * *

"The Best Coverage at the Lowest Cost"

The public is understandably bewildered by the extravagant claims of some commercial companies writing hospital and medical expense insurance. The benefits advertised sound too good to be true—and many of them are. As previously reported in this column, complaints from disillusioned policyholders have prompted Federal, state and local governments to move into this field for a look at what is going on ("Fine Print Spurs Probes," Medical Annals of the District of Columbia, February, 1954).

In these circumstances the prospective buyer has become wary, and not infrequently turns to his doctor for advice. The doctor may or may not be sufficiently well informed to be helpful. Chances are he isn't.

The purpose of these comments is to urge the doctor to inform himself sufficiently to provide his patients with reliable information. He does not have to be an expert in insurance but he should have a knowledge of essential facts. These were very well stated in an article, "The Truth About Health Insurance," which appeared in the December 1953 issue of the Kiplinger Magazine, *Changing Times*. The writer describes in simple nontechnical terms what is considered "the best coverage at the lowest cost." "It looks hard [to buy the most desirable health insurance protection]," the *Times* states, "but it isn't so bad, really."

> "You want protection against bad and expensive events that are unpredictable but well within the realm of possibility. But you would be foolish to buy health insurance to reimburse you for routine visits to the doctor, dental care, physical examinations, shots for the children, etc. These are predictable.You know you are going to have a certain number every year. Therefore they should be taken care of by budgeting. To buy insurance against routine events is merely trading dollars with the insurance company. You pay premiums, and the company pays the money back in claims minus the 15 per cent to 50 per cent deducted for overhead and profits. So you are just paying the company to do your budgeting."

On the basis of this observation, the *Times* offers five rules for the guidance of its readers:

"1. Don't try to insure against routine or predictable expenses.

2. Don't buy a policy just because it has an intriguing clause saying you will get $10,000 if you lose two limbs in a railroad accident. That is about as likely to happen as your being bitten by a cobra.

3. Concentrate on policies that will reimburse you substantially for substantial expenditures.

4. Try to get in on a group policy.

5. Look with favor on being your own coinsurer."

Preference is given the Blue Cross group hospitalization plans because, the *Times* states, they are written on a group basis, therefore less costly, and, of course, they are nonprofit. Monthly premiums are usually very modest, varying in amount from 60 cents to $2.80 per month for individuals enrolled in groups. For families the figure is $1.50 to $6.75 per month. In return for these premiums the Blue Cross pays hospital costs for a definite number of days, usually 30, and for an additional number of days, the figure varying in different communities, at half the regular rate.

Priority is also given Blue Shield plans, it being pointed out that these plans are sponsored by physicians and are operated on a nonprofit basis. Here, again, it is desirable, according to the *Times*, for individuals and families to subscribe on a group basis although they can do so as individuals at a slightly higher cost.

There is usually a fee schedule in connection with Blue Shield plans, physicians agreeing to accept fees as payment in full except from those over the income limit. In the District of Columbia the following income levels are in effect: $3,000 for an individual and $5,500 for a family. Subscribers' rates range from 40 cents to $4.70 for an individual and from $1.15 to $10.50 per month for families.

The next category on the *Times'* list of desirable protection is catastrophe insurance now available through commercial insurance companies. An example of the type of protection afforded by this coverage is deductible automobile insurance. In other words, the insured individual agrees that he will pay a specified amount for medical services, let us say $500, before he is entitled to benefits under his policy, then the insurance company will pay medical costs up to a maximum of $5,000. Obviously, the higher the deductible amount the less costly the coverage.

The final type of coverage recommended is disability insurance, which protects the policyholder against loss of income. Here, too, group buying is recommended. Where there is not a sufficient number of persons to organize a group, the reader is advised to see a reliable insurance agent or broker. As in catastrophe insurance, the deductible feature is most important. The buyer can save a great deal by lengthening the waiting period, which is usually two weeks.

Before purchasing any of the above protection, the purchaser is advised to read his policy carefully, thus avoiding needless misunderstanding. It is especially important for him to know the conditions under which his policies can be cancelled, at what age they can or will be terminated, and under what conditions, if any, policies can be continued in force after, say, age 60 or 65.

Of especial significance to physicians is the high rating given the Blue Cross and Blue Shield plans. Should such plans not be available to prospective buyers, the *Times* recommends that the buyer proceed very carefully in selecting a commercial company, which means, usually, the choice of a reputable agent.

If the buyer feels competent to do so, it is recommended that he prepare a memorandum setting forth what he considers his insurance needs. In this way he can compare what each company has to offer. Usually, he is not technically competent to analyze a policy by himself and so he should ask all the questions that come to his mind. He might inquire, for example, whether the company is licensed to write insurance in the community. This information can usually be obtained from the bank with which he does business, or he can write to the insurance department in the state in which he lives.

Just a final word to physicians participating in Washington's Blue Shield Plan. Why not sit down a few minutes with the administrator of your Plan? Learn something about its operation and how it can benefit your patients. This knowledge will be helpful to you and appreciated by them.

For the benefit of those who do not know him, Mr. George B. McGovern is Manager of the Washington Plan, which is known as Medical Service of the District of Columbia; his telephone number is REpublic 7-5000. Give him a ring and arrange for an appointment!

★

More Prestige, but— Why has the medical profession been the subject of public controversy for more than a decade? Most physicians queried on this subject have their own pet theories, among them the socialistic trend in government; the highly organized and sometimes subtle propaganda campaign against organized medicine, having its origin in the New Deal; the affluence of many physicians and its psychologic effect on public opinion; the unprofessional behavior of a minority of physicians; and the unrealistic attitude of organized medicine toward the social and economic aspects of medical care.

Mr. Herrymon Maurer, author of "The M.D.'s Are Off Their Pedestal," which appears in the February issue of *Fortune*, offers a more satisfactory appraisal where the medical profession is concerned. He, too, poses the question about public controversy and asks, "Why should the halo that once set evenly upon the physician's head have been twisted askew?"

> "The layman's suspicion of the doctor's income may be the ostensible reason," Mr. Maurer writes, "but basically, if subconsciously, the real reason is better medical practice. Paradoxically, the more specifically and successfully the physician treats patients, the less is his personal prestige. Compared to the physicians of past generations, he keeps a considerably greater percentage of people in every age bracket alive, an even greater percentage in general good health. But he can no longer surround primitive methods with an aura of mystery and authority. He no longer dozes beside a sickbed the night long. Such procedures once gave confidence to the patient and his family, kept away intruding neighbors, and—since, as doctors themselves point out, nature worked cures in most cases—won the physician acclaim as 'the man who pulled Aunt Emmie through.'
>
> "Today, however, the old-fashioned doctor has gone with the old-fashioned family. With new aids to diagnosis, new treatments, and new drugs, any competent physician can accomplish more and quicker cures than he can with any amount of bedside attendance. Under these circumstances patients credit the treatment, not the physician, with keeping them well. The uncritical awe that used to be given to the individual physician is now given to medicine in general despite the obvious fact that medicine can be nothing more than the activities of the men who practice it. There is public ignorance of the state of the medical profession. Therefore there is public and sensational controversy."

If Mr. Maurer's premise is correct, medical organizations should reëxamine their public relations programs. There is obviously something wrong if, as he says, treatment has taken on more importance in the public mind than the one who administers it. Perhaps the fault lies largely with the physician himself, that he is so engrossed in the science of his profession, he no longer impresses his patients with his human qualities.

There is nothing new about this observation, for it is frequently made by medical men themselves. Mr. Maurer's comments, however, are a reminder that doctors are the key to good medical public relations. Without their active participation, public relations programs have no reason for being.

★

"Little Learning—with Illustrations"

On occasion one hears doctors protest that they have been "oversold" to the public. Medicine, they say, is not an exact science and they are not miracle men. True, tremendous strides have been made in diagnosis and treatment, with the result that many diseases previously disabling, if not fatal, have been practically eliminated. But there are still large areas about which the physician knows little. If this were generally understood doctors would not be looked upon as supermen who can do no wrong, but as serious, well-trained practitioners of medicine who seek to provide the best medical care of which they are capable.

Who is responsible for overselling the doctor? Certainly it cannot be laid at the physician's door, for he has vigorously protested the ever-increasing optimistic statements about recent developments in medicine which find their way into our newspapers and magazines. Especially objectionable, from a physician's standpoint, has been the manner in which medical subjects have been presented in so-called mass circulation slicks.

Most doctors have had patients come to them after reading such articles, either to request the treatment described, or to confirm the truth of what was stated. Usually, the physician finds that the statements were accurate but that the emphasis on the more hopeful aspects of some new and comparatively untried drug or surgical procedure is not warranted. As has been stated, so far protests against this sort of publicity have gone unheeded; in fact, objectionable medical articles seem to be on the increase.

In a recent issue of the *Saturday Review*, there appeared an article by Edith M. Stern, herself a writer of medical articles for the laity, expressing serious qualms about the effect they were having on lay readers. In her article "Medical Journalism—With and Without Upbeat," she states:

> "Sometimes I feel like sitting at my typewriter with my hands folded. I don't like popularization. It has gone too far. The little learning—with illustrations—which the magazines have been pouring into a thirsty public has become a dangerous thing.
>
> "One reason is that false hopes inspired by medical articles with such recurring titles as 'There's Hope For . . .' and 'Good News About . . .' can disrupt peace of mind and body far more than honest acceptance of the facts. Take my own case, for instance. I've sincerely believed the many articles I've both written and read about how chronic conditions can be prevented through regular physical checkups and how the aging needn't be old—after all, weren't these pieces documented by quotes from reputable physicians? When I developed mildly incapacitating osteoarthritis, therefore, I underwent quite an emotional shock; this shouldn't happen to anybody, and couldn't happen to me! My uninformed mother and grandmother, who had only old Doc to educate them, would have shrugged off twinges and creakings like mine as something quite to be expected in their early fifties."
>
> "Since reputable writers and editors (motivated by a combination of self-protection and integrity) tend to get expert checking before publication, factual inaccuracy as a rule is least among the factors which transmute what should be merely a report on a hopeful experiment into joyous hailing of a sure cure. An important one is readers' wishful thinking. Another is the highly competitive slicks' need for scoops; hence new medical discoveries are played up, truthfully enough, before time and further research play them down."

Miss Stern says she does not suggest a moratorium on lay medical articles, neither would she "pass a law" to restrict medical information to scientific journals, but she insists that "there

(*Continued on page 186*)

THE KINSEY REPORTS ON HUMAN SEXUAL BEHAVIOR[1, 2]

A Critical Evaluation

PRENTISS WILLSON, M.D.
Venice, Florida

As allegedly thinking beings, whether the phenomenon of the existence of terrestrial human life be approached from a frankly theistic, an agnostic, or even an atheistic point of view, the fact remains that its continuance is obviously predicated solely on sexual reproduction. The conduct of the birds, observed on your feeding tray in the morning, clearly indicates the importance of the instincts associated with hunger, thirst and fear in preserving life *in esse*. But, since all such life, and life *in posse* as well, is limited in duration, whether measured in terms of hours, as in the case of the Mayflies, or, in tens of centuries, as in the case of the giant Sequoias, it would appear to be incontrovertible that creation itself, and with it all life, would either terminate, or, at the very least, revert to the time of primordial evolutionary change, were it not for sex. What, then, would be a correct estimate of its importance?

For this and other reasons, it is the considered opinion of this critic that these two volumes by Dr. Kinsey and his co-authors constitute a fundamentally valuable, valid, and even a valiant attempt to throw some much needed illumination into those dark corridors of current thought, at the entrances to which one now all too often finds inscribed overhead the dread word "*verboten*." In view of this latter consideration alone, these texts[1, 2] may, in time, come to be regarded as having been truly epochal.

They do not constitute pleasant reading. Much biologic literature does not do so, particularly for those who are too squeamish to relish facing the facts of animal, not to mention human, sexuality. They are, however, obviously addressed to an adult, and what it was hoped would prove to be an educated and thinking audience. They have been subjected to rather bitter, and, from some quarters, an almost vindictive criticism, much of which, to the mind of this writer, is not only shown to have been anticipated but to have been already succinctly answered in the current volume under such chapter headings as Historical Background, Scientific Objectives, Individual Right to Know, Problems of Marital Adjustment, etc. The publication of these volumes for the laity, rather than as a medical text, was, of course, done deliberately in order to secure the widest possible circulation. How successfully this has been accomplished is shown by their current place on the list of best sellers.

The pornographically-minded youth, male or female, seeking a vicarious, salacious thrill through the perusal of these pages is going to be bitterly disappointed. The treatment is too statistical and the verbiage too technically medical for average adolescent comprehension.

As to the validity of the statistical method of dealing with these findings, the writer has neither the knowledge nor the experience to make his opinion of any importance. He would, however, rely without hesitation, not only on the eminence of the authors, but to an equal extent on the significant prestige of the members of the Committee for Research on Problems of Sex, Medical Division, National Research Council, whose names are listed at the beginning of this volume. These names are as follows:

George W. Corner, M.D., *Chairman*, Director, Department of Embryology, Carnegie Institute of Washington and Baltimore

Willard M. Allen, M.D., Professor of Obstetrics and Gynecology, Washington University

Clyde L. Kluckhohn, Ph.D., Professor of Anthropology, Harvard University

Karl S. Lashley, Ph.D., Professor of Psychology, Harvard University; Director, Yerkes Laboratories for Primate Biology, Orange Park, Florida

C. N. H. Long, D.Sc., M.D., Professor of Physicological Chemistry, Yale University.

Carl R. Moore, Ph.D., M.D., Professor of Zoology, The University of Chicago

James V. Neel, Ph.D., Geneticist, Laboratory of Vertebrate Zoölogy, University of Michigan

Milton C. Winternitz, M.D., *ex officio*, Director, Division of Medical Sciences, National Research Council, Washington, D.C.

All of these data concerning human sexuality are so fundamentally important, and to such an extent do they impinge on human life in general, that one has difficulty in determining the correct point at which to initiate their critical consideration. However, since physicians, from the very nature of their profession, are forced to be socially conscious, and since, from pediatrics to geriatrics, nearly every specialty of medical practice is concerned with sexual problems, their consideration from a medical point of view would seem to be indicated as the correct point of departure.

The phenomenon of the apparently ever-increasing divorce rate in the United States is one that should certainly merit our most serious consideration, both as physicians and sociologists. Since a large factor in this problem is demonstrated in these texts to have its origin in sexual maladjustment in marriage, certainly as physicians we should be profoundly concerned with it. It touches, intimately, the practice of obstetrics and gynecology. Furthermore, since the recently demonstrated fact that it and the problem of juvenile delinquency run *pari passu*, it becomes of equal concern to the pediatrician. The latter should also give thoughtful consideration to the statistics concerning precocious juvenile sexuality. The obstetrician, gynecologist and abdominal surgeon must give thought to the question of the extent to which the dread of excessive childbearing may contribute to this primary problem. With adequate consultative precautions would this not result in the revision and possible liberalization of their present views on this subject? As for the specialty of neuropsychiatry, its members know only too well what proportion of their work involves sexual problems, and even they might profit by some reëxamination of their thought along these lines, from the care of mental defectives to postpartum psychoses.

Finally, as physicians, what, then, under the aegis of our current predominately Judeo-Christian culture, should be the orientation of our thinking concerning the religious, ethical and moral, legislative and legal problems so clearly shown herein to be inextricably associated with sex? Probably, as physicians, the most sensible course to pursue would be to recall the truth of the old adage that "Fools rush in where angels fear to tread." But the doctor is usually no fool! However, this one cannot refrain from venturing the opinion that, ultimately, an informed public opinion, further educated by other equally frank volumes, will play a definite role in the solution of these questions, even the religious ones.

The two current volumes are mainly a statistical study of human sexuality, under the conditions of modern culture and civilization. The amount of material made available for this type of study is truly remarkable, consisting of case histories and questionnaires covering 5,300 males and 5,940 females, a grand total of 11,240 cases. Since men and women are ordinarily referred to as such and not as human males and females, to the mind of the reviewer the connotations of these titles are essentially more biologic than statistical. Very fortunately, therefore, the approach to the problem has been admirably phylogenetic, and hence the volumes contain a wealth of biologic data dealing with mammalian, and to some slight extent even with reptilian, sexual conduct. The fundamental importance of these biologic data is immediately demonstrated by their disclosure of the apparently little known or understood fact that practically every one of what we humans have been pleased to term aberrations of human sexuality has been phylogenetically foreshadowed in general mammalian sexual conduct. The importance of this one fact alone would seem to indicate that a more detailed consideration and comparison of the pre-anthropoid and anthropoid sexual conduct might very advantageously have been employed.

It is for this reason that this critic finds the temerity to venture this suggestion. Should not advantage be taken of any future textual revision of these works, particularly did it involve publication of a new edition, to convert this duo of volumes into a trilogy of monographs. The first volume would be the one as yet unpublished. This would cover in more detail the phenomena of pre-anthropoid mammalian sexuality. Then should follow a detailed consideration of the analogies and differences between sexuality in the human female and the other anthropoids. This would be followed by discussion of human sexuality in pre-literate cultures, particularly the most primitive and aboriginal. In conclusion, an attempt should be made to show when, to what extent, and why women's sexual conduct might have been expected to deviate physiologically from that of the other primates when once it became "sicklied o'er by the pale cast of thought" and thus, modified, and to what extent, by modern cultures and religious thinking.

Even casual observation of the sexual conduct of your female household pets will demonstrate the fact that in them, and apparently all other pre-anthropoid mammalian females, genital bleeding is not menstruation but indicative of the initiation of a usually comparatively short period of oestrus, during which ovulation occurs. In the vernacular, this condition is referred to as "being in heat." With the exception of some occasional sexual play, usually homosexual in character, and indicative of the forementioned aberrations, these females are not only disinterested in, but refuse actual coitus.

It now becomes necessary to give some brief consideration to a comparison between such a type of lower mammalian sexual physiology and that of the Primates. This order includes not only man and the great apes, the chimpanzee, gorilla, orangutan, and the two or three species of gibbons, but also the marmosets and the lemurs. There are two suborders, the Lemuroidea and the Anthropoidea. Fortunately, observations reported by Yerkes and Elder,[3, 4] and by others, mainly from the Yale Laboratories of Primate Biology in Orange Park, Florida, enable us to give a somewhat detailed account of the analogies and discrepancies between the sexuality of women and female chimpanzees. There are also scattered observations in general biologic literature indicating that these comparisons hold also for the other great apes. It is unnecessary for us to attempt here to trace them phylogenetically lower in the order.

Except when pregnant or lactating, women and the female chimpanzee both menstruate at comparatively frequent intervals during their period of sexual maturity. In woman, this interval averages about 4 weeks; in the chimpanzee about 5. In each, menstruation indicates not the initiation of a period of oestrus but its failure to have resulted in conception during the previous menstrual cycle. Also, in each, oestrus occurs about the mid period of their menstrual cycles. In women its initiation is usually unmarked, except very rarely by an extremely slight spotting of blood. In the chimpanzee, however, it is indicated by some tumefaction of the labia and introitus and by a very decided change in sexual conduct, which, according to human standards, could only be termed outrageous. Posturally and in many other ways she now invites coitus quite constantly. As the time of oestrus recedes, her sexual conduct gradually changes, and while, like woman, anatomically capable of intercourse at any time in the menstrual cycle, or even during pregnancy or lactation, she now tends to use such sexual capacity only as a placatory resource against a too-aggressive male.

Perhaps, considering this writer's opinion of the fundamental importance of the observations in these volumes, particularly in the second on women's sexual behavior, this critique would have been best concluded at this point. It is continued solely for one reason, namely, that for over a third of a century, his practice was not only entirely and absolutely limited to women, but to dealing solely with their obstetric and gynecologic problems. During this period this practice consisted of a group of patients numerically considerably larger than the 5,490 women covered in this statistical report. Apparently, however, they were predominately from the same upper middle class. He feels that his severest critic should be prepared to admit that this experience might, at the very least, have taught him something concerning women's sexual behavior. It should be indubitably clear, however, that any of his critical comment or suggestions are to be evaluated against the preceding unqualified endorsement of the importance of, and necessity for, the factual material contained in these publications. Considering the nature of the practice just cited, it is only natural that the current volume does not contain too many factual data foreign to his experience.

With respect to the extent of the premarital petting and the frequency with which it results in intercourse and hence, all too often, in conception, the writer has delivered too many full-term babies, the dates on whose birth certificates did not either physiologically or chronologically coincide with those of parents' marriage certificates, to have been too greatly astonished by these findings.

As to the statistics covering intramarital coitus, one may, at least, say that it seems to occur with sufficient frequency to support the obstetricians.

With regard to the statistics on extramarital intercourse, the experience of this critic would indicate that its frequency in married women has been exaggerated.

As to homosexuality in women, he can only say that in his long practice, to the best of his recollection, the subject has never been brought up in his consulting room more than three or four times. Therefore, his opinion would have to be that this report also gives an exaggerated idea of its frequency. Nevertheless, a psychiatrist might very possibly entertain a different point of view. But, whatever the sociological, clinical, psychiatric, or moral aspects of Lesbianism may be, can anyone suggest a more effective method of birth control? Since this is, of course, self-evident, one cannot avoid wondering to what extent such considerations play an etiologic role in the occurrence of this type of conduct. This reviewer cannot escape the conclusion that, if possible, a statistical study of the subject along these lines might prove to be illuminating and of great value.

The mention of birth control brings me to the conclusion of these remarks. In my practice, requests for information and advice concerning it were practically a daily occurrence in my office, and these came in approximately equal numbers from the Jewish, Catholic, Protestant and agnostic groups of my patients. As a matter of fact, under the exigencies of modern culture and civilization, it should be an accepted fact that some method of birth control is not only an absolute *sine qua non*, but that it is also almost universally employed by married women. If this be true with respect to them, it certainly is obviously even more true of extramarital sexuality, whether adulterous or not.

How, then, one can write an adequate and exhaustive treatise, statistical or otherwise, on the "Sexual Behavior in the Human Female" without giving extensive consideration to the subject of contraception, which is obviously so vital a factor in its determination, is completely beyond this writer's comprehension or understanding. Indeed, this omission is one of the most astonishing facts about the volume. One would think the new volume was to deal solely with the sexuality of the Australian aborigines. So astounding is this omission that one cannot help but wonder if the motivation for its omission is not to be found in the fear of the publishers of potential best sellers that they would encounter the usual resistance from the Roman Catholic Church.

But look, however, in the index of this volume. One will not find the dread words "birth control." Look now to see if the Catholic version of rhythm is mentioned. You will be referred to page 509, careful perusal of which will finally elicit for you, as part of one sentence, information to the effect that some music, particularly waltz tunes, has an aphrodisiac effect on humans!

Still speaking of birth control with respect to rhythm, my belief, based on long experience in my practice, is that it is an entirely workable method of contraception for the group of women whose menstrual cycles are not too arhythmical. Why the other group, which is of considerable size, has apparently been so unjustly discriminated against in the scheme of life would seem to need explanation, but not by this writer. There are three other points concerning rhythm on which I would like to comment. First, I have always wondered why, according to some standards, the deliberate control of human fertility by chemical, and/or mechanical means, constitutes such a heinous crime when its equally deliberate control by avoiding sexual relations at certain times does not. Second, I cannot help but wonder whether modern woman has completely escaped from those tides of desire which have been demonstrated to run so strongly at the peak of fertility in her nearest primate relative, the chimpanzee. Third, and in final conclusion, if this point be susceptible of statistical analysis, as it well might be, would not such a study be both interesting and informative?

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MEDICAL BINDINGS AND BOUNDARIES*

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I was inspired a short time ago to write a paper on books that have influenced the medical profession rightly or wrongly since the dawn of medicine. This inspiration arose from a second reading of Dr. Harvey Cushing's "The Binding Influence of a Library on a Subdividing Profession," an address given at the dedication of the William H. Welch Library of Johns Hopkins in Baltimore, October 17, 1929. "*Omnia Gallia in tres partes divisa est*"; those of you who don't know your Latin will fear that I'm about to refer to the gallbladder, although this organ in itself is the basis of many an old wive's tale. I think we may well be divided into three classes, namely, those who think and write, those who think and don't write, and those who just write. I think of myself in this last division.

The earliest books on ancient medicine known to us are those of the Egyptians. Extremely interesting, and a rarity that a Rosenbach or a Southby might have acquired, if one could find it, would be an account (first edition, first issue, with points, of course) of the delivery of Eve from Adam's rib. There is a picture of this in the *Nuremberg Chronicle* on the table. This would have been the first obstetrical manual in existence, and somewhat of a curiosity nowadays, as the only example of a male conception and delivery, especially in, or near, the kidney region. Secondly, the question of the apple eaten by Eve, and what eye-opener could it have been?—hormones, vitamins, or just another product so often advertised in Paris, "*pour les hommes malade.*"

Medicine "was fathered by the Gods" and attended to by the priest for the most part; and the medicine man, half priest, half magician, has descended to us in this present time. Imhotep was an Egyptian, leader to the King of the third dynasty in 4500 B.C. He was "Grand Vizier to the Pharaoh, Chief Judge, Overseer of the King's Record, Bearer of the Royal Seal, Chief of all Works of the King, Superior of that which Heaven brings, the Earth creates, the Nile brings, and Superior of everything in this entire land." What a man! And in his spare moments he took care of the sick and needy. But he left no written records, although he was to the Egyptians what Aesculapius was to the Greeks—a mortal man transformed into a god of healing. We find him in Homer—a mortal, a physician, and later the God of Medicine and Healing, a son of Apollo, slain by Zeus for attaining such skill that he raised the dead. No scrolls of his have as yet been found, probably also having been blasted by Zeus to effect a complete clean-up.

But Hippocrates was a gentleman of another cloth. He would come under the classification of one who thought and wrote, although no one knows for certain whether his "Works," put together in the fourth century B.C., were written by him or his pupils. Authorities admit the possibility of either. Parts of these "Works" may be found in one of the earliest books printed in Greek, the "Omnia Opera," Venice, 1526, now in the Harvey Cushing Collection of Books and Manuscripts at the Yale Medical Library. There is also another, "Libri Omnes," in the collection, published in Greek in Basel, Switzerland, by Froben, 1538. This great printing house of the century was established in 1491, but naturally the first book published was the Bible. We must remember that although the history of medicine goes back to the beginning of civilization, with records on clay tablets, later papyri, and vellum, the dissemination of knowledge was only achieved by the invention of the printing press and movable type, in 1455, by Gutenberg. The Gutenberg Bible, of which there are to this day only 45 known survivors, was the first work published. But only two years later, in 1457, appears the first treatise on medicine, according to Osler, the "Mainz Kalendar," which is in the Bibliotheque National in Paris and contains a "purgation calendar." Perhaps this is a forerunner of our for the most part diabolical laxative advertisements and radio commercials.

We seem to find nothing now until 1480, when the medical school at Salerno, near Naples, printed the Regimen Sanitatis Salernitanum, written for the use of "King" Robert, largely a code of health for the layman. "King" Robert is supposed to have been Robert of Normandy, a fictitious King of

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* Read before the Clinico-Pathological Society of Washington, D. C., November 18, 1952.

England, and the verses in doggerel Latin have been translated into almost every European language. The school itself is supposed to have been the earliest university in Europe, and, according to one author, a place of bogus degrees in the Middle Ages, finally closed down by Napoleon in 1811. This same year, 1480, appeared also the first practical medical dictionary, the "Aggregator Paduarus de Medicinis," The Padua Dictionary of Medicine. In 1493, the year after the discovery of America, the Venetian Press of De Gregoriis printed Ketham's "Fasciculus Medicinae." This same press was famous for another great book printed the previous year, not a medical book, but one of which you all have heard, Boccaccio's "Decameron," most rare because of its suppression in even those hilarious days when beds were used partially for pure sleeping, but apparently for the most part were whistle stops on a wide and active thoroughfare.

It was at this time also, in 1494, that Schedel's "Illustrated History of the Worlds," *The Nuremberg Chronicle*, appeared, the earliest best seller known to us, comparable to nothing that we have today, a mixture of the *National Geographic Magazine* and Van Loon's "History of Mankind." In it are two medical pictures, the first showing Eve springing full-blown from Adam's rib, under the influence of an early anesthetic, and the other malformations in children, e.g., extra legs and extra arms.

We have spoken of the first medical school in Europe, the earliest Public Health Guide, and the first dictionary. The first text on anatomy was Mondino's "Anathomia," completed in 1316, first published in Padua in 1487, no copy of which is known; a second edition appeared in 1493 from a Leipzig Press. Mondino was professor at the University of Bologna until he died in 1325. It seems that he himself did no dissecting but looked on from an elevated rostrum while a barber with a large butcher knife carried on gaily. Another most rare book in anatomy is one by Versalius, 1543.

The "Buch der Chirurgia," 1497, by Hieronymus Brunschwig is the oldest printed book in German on surgery, the first printed since Gutenberg's discovery. I wish that I might read you passages from these various texts, but my Latin and Greek fell behind me as I wandered through the halls and classrooms of the medical school. Soon, however, I shall be able to quote from English texts, in which language I made more progress as time went on.

But let me finish with early surgery. Many tomes appeared since the work by Brunschwig, but one of the most important was "Les Oeuvres de M. Ambroise Paré," 1575, by one of the most famous French surgeons of the 16th century. He was first apprenticed as a barber surgeon and studied at the Hotel Dieu for three years. Many of you have seen the modern Hotel Dieu erected during 1868 to 1878 and recall its grisly charm. What must have been the condition of the old Hotel Dieu where Paré studied, erected in 660 A.D. under Clovis II, one of the oldest hospitals in Paris or Europe! It was Paré who instituted ligatures in place of hot irons and boiling oils in amputations, but for this he was bitterly criticized by his colleagues. He was also one of the few in his time to take an interest in obstetrics and help the midwives, much to the dismay of physicians, who considered midwifery beneath them. This attitude has prevailed until quite recently, say 50 years or less, especially in England. Paré adhered to the teachings of Hippocrates, whose works I have mentioned, of Aristotle, and of the Arabians, sharing partially with all superstitions, which die hard. But he could not adhere to the ancient old wive's tale that monstrous and monster babies were begotten by the devil. "It is much less credible," said he, "that Devells can copulate with women, for they are an absolute spiritous nature, but blood and flesh are necessary for the generation of man. How can they who neither ate nor dranke be said to swell with seed?" On the other hand, he also said, "Outlaws forgetful of their own excellency and divinity, and transformed by filthy lust, have not doubted to have filthy and abominable copulation with beasts. For of this various and promiscuous confusion of seeds of different kinds, monsters have been generated and borne, who have been partly men and partly beasts."

It is interesting too to find the origin of present tales of the old wives. Paré reported that a baby turned by instinct from a breech to a head presentation at the seventh month, and if born then would more surely live than if born in the eighth month.

In medicine, although there was little differentiation in the arts in the 16th century, an outstanding example was a treatise by Paulus Aigineta, printed by Simon de Colines in 1532. Another example of the work of this press I have brought with me tonight, "De Dissectione Partium Corporis," a book on dissection by Stephano Riverio, surgeon, published in 1545. Note its interesting anatomical charts with a strong wind blowing nerves and blood vessels about.

Finally we come to William Harvey, 1578 to 1657, the author of "De Motu Cordis," the treatise on the circulation of the blood, in 1628, and the real beginning of physiology. Until this time the blood was thought to ebb and flow, as the tides, perhaps, in the Thames River. Harvey studied at Padua from 1599 to 1603—even in those days the medical curriculum required four years. In 1928, another Harvey, certainly a worthy person to bear the name, Dr. Harvey William Cushing (as opposed to William Harvey) could not overlook the opportunity of this 300th anniversary. As John Fulton in his biography of Harvey Cushing says, "The year 1928 marked the 300th anniversary of the publication of William Harvey's book, 'De Motu Cordis,' announcing the discovery of the circulation." As with the Pasteur Centenary, this was another great event to be celebrated by Dr. Cushing; not only did he collect Harvey items with great diligence throughout the year, acquiring a copy of the rare first edition (20 years previously he had had to turn down a copy priced at $200), but he also arranged a Harvey Meeting for the Harvard Medical Society. A creditable exhibit of Harveian items, made up of his own possessions and others that he had begged or borrowed from his friends, was arranged in the amphitheatre of the Peter Bent Brigham Hospital, and Archibald Mallock, Librarian of the New .York Academy of Medicine, read a detailed paper on Harvey, which was subsequently published in monographic form. Cushing, as one might have anticipated, insisted that his house officers present a number of cases of circulatory aberration, which, like some of the books, had been borrowed for the occasion.

This publication, that is, "De Motu Cordis," and the man behind it, started an endless chain—over 44 items in the Cushing Collection at Yale, the foundation of innumerable Harvey Societies, the rejuvenation of the Harveian Orations, begun in 1680 and continuing with occasional breaks until the present time.

A later edition by Harvey, in 1653, and the first in English, "The Anatomical Exercises," concerning the motion of the heart and blood, was published in London. I regret that I have only the second English edition, published in 1673, which I brought with me tonight. It has obviously been rebound, but still is worth having.

Modern medicine, or at least modern physiology, may be said to have started with William Harvey. Quickly there followed Boyle the chemist; Boerhaave, the great "bedside" teacher, the one first to bring patient and theory together; and his Swiss pupil Albrecht von Haller, whose "Elements of the Physiology of the Human Body" (1759–1766) is still quoted. But now we are in the stream of books, medical books, books on history, books of literary value, some of which we like to read. Undoubtedly many manuscripts and learned treatises dropped to the bottom of the stream, some to be hooked by patient fishermen in years to come, but most to be buried in what is known to geologists as primeval sludge. And most were perhaps no better than the sludge itself. Fortunately today there is still sludge, and not every book published can escape it. Many books and articles written should never have left the quivering pen of inadequately prepared authors, whose knowledge has been meager but whose enthusiasm has been boundless. Indiscriminate writing is surely worse than no writing at all.

The stream moves on. Floating high on the surface we find Laennec's "De L'Auscultate Mediate," a treatise on the diagnosis of maladies of the lungs and of the heart, 1819. In this year too he devised the stethoscope. Laennec began the study of medicine in Nantes before he was 15 years old, later coming to the University of Paris. His works have been translated into practically all the European languages and were the basis of study for years. Note that now, and beginning even earlier, the medical books are being printed in the language of the country of origin, not necessarily remaining in Latin.

I seem to have forgotten my own peculiarity, namely, that of obstetrics. In early days we were midwives, and I have in mind a tale of one progressive barber surgeon who wanted to see what it was all about. Dressed up as a woman, and with bag in hand, he advanced to a lady in the throes of childbirth. Ducking under the voluminous and most unsanitary skirts, petticoats, red flannels, and the like, he—the impersonated she—produced the baby without benefit of candle. I don't know what happened, perhaps the beard was too pronounced, but when he came up for air the male midwife was apprehended and sent to Newgate Gaol, perhaps to be hanged. You can see that it was a very scary specialty.

But what of the Chamberlens, father and sons and grandsons. I was interested in Peter the Elder, born in England in 1560, who lived in London and was said to have invented the "iron tongs,"—obstetrical forceps to you. He was a barber surgeon, and as such was forbidden to prescribe; he could only teach anatomy with readings from Versalius, Galen and Harvey, dissect, bleed, cut, or do midwifery. The slur is gradually being lifted from the male midwife. Barber surgeons were definitely of a lower order than the great physicians, and to this day in England surgeons retain the once degrading title of "Mister," now considering it a mark of distinction.

Peter Chamberlen the younger was also born in England and there was much confusion between the two, although both were equally chastised by the Great College of Physicians, and even imprisoned, for presuming to prescribe medicine and not sticking to their leeches or blood-letting basin. As all of you know, the red and white striped barber pole represents a bloody bandage around an arm or a leg, while the basin with a circular notch in one side, hung outside of barber shops, especially in England, represents the blood-letting bowl.

Be that as it may, the Chamberlens carried the partial secret of the iron tongs through at least three generations, but finally came to grief. Hugh, the grandson of Peter the younger, came upon hard times and tried to sell his forceps in France for 10,000 livres, about $2,000. He said he could deliver any difficult case in a few moments, but in a test by the famous Moriceau, foremost French obstetrician of the 17th century, Hugh killed both the mother and child. The forceps apparently were not sold. But as he needed money, he journeyed to Holland and there sold the family secret to Roonhuysen for a sum. It came out, however, that he held back a little; he sold only one forceps blade, pretending he knew nothing of the second.

Only in passing will I mention Smellie, 1697–1763, the "Master of British Midwifery," not because he was a minor figure, which he certainly was not, but already have I devoted too much time to my own specialty. A few of his books are on the table where those interested may see them. To him goes much of the credit of making obstetrics a science itself rather than a stepbrother of surgery. But I wish that even today surgeons would avoid doing obstetrics, for only last week I saw one cesarean scar from symphysis to xiphoid, long enough to deliver the full-grown Eve. Look at the picture in *The Nuremberg Chronicle.*

I really intended this to be a brief account of Medical Books and Bindings, some of which I have brought with me, others of which I wish I had to bring. We spoke last of William Smellie of the 17th and 18th century. But we haven't even mentioned Hunter, or Baudelocque, or Naegele, or others, whose works are definite milestones. But let us pause for a moment with Oliver Wendell Holmes, nearer our time, nearer our hearts, because of his very understanding writings. Born in 1809, he died in 1894, a writer, a philosopher, and a man of medicine. It was he who christened the *Atlantic Monthly.* It was he who authored "The Chambered Nautilus"; and, of course, "The Autocrat," then "The Professor," one succeeding the other at the breakfast table, will never be forgotten. There are several copies on the table, one annotated by him, others signed. Tonight we also venerate him for his article on puerperal fever. At this time Dr. Holmes was Parkman Professor of Anatomy and Physiology at Harvard University. In an essay read before the Boston Society for Medical Improvement, and printed in the *New England Quarterly Journal of Medicine and Surgery* for April 1843, Dr. Holmes says, "The disease known as Puerperal Fever is so far contagious as to be frequently carried from patient to patient by physicians and nurses." It is an extraordinary article and, of course, not accepted. Professor Hodge of the University of Pennslyvania reverberates: "The result of the whole discussion will, I trust, serve, not only to exalt your views of the value and dignity of our profession, but to divest your minds of the overpowering dread that you can ever become, especially to women, under the extremely interesting circumstances of gestation and parturition, the minister of evil; that you can ever convey, in any possible manner, a horrible virus, so destructive in its effects, and so mysterious in its operation, as that attributed to puerperal fever."

Professor Meigs shouts, "I prefer to attribute them (the fatal cases) to accident, or Providence, of which I can form a conception, rather than to a contagion of which I cannot form any clear idea, at least as to this particular malady." These were remarks in 1852, 100 years ago.

And so the dispute raged. But it was no different—to forget obstetrics now and return to medicine—when Jenner made "An Inquiry into the Cause and Effects of the Varioloe Vaccinae, a disease discovered in some of the Western Countries of England—and known by the name of Cow Pox." A doctor Woodville, Physician to the Small-pox and Inoculation Hospital in London, found it improbable and exceedingly inconvenient to himself that cowpox should prevent smallpox; but nevertheless Dr. Jenner proved otherwise.

It was no different when in 1847 "Some Account of the Letheon or, Who Was the Discoverer?" by Edward Warren was published in Boston. Here, however, the question was not so much as to the efficacy as to the one who did it. The Solid South was all for Dr. Crawford Long, who operated, I believe, in 1842, on a patient under sulfuric ether to extract some teeth. In 1846 Dr. W. T. G. Morton employed sulfuric ether in an operation for the removal of a tumor of the neck. It was successful, i.e., the anesthesia, and Dr. Warren is reported to have said, "Gentlemen, this is no humbug." There is a statue of Dr. Long in the Capitol in Washington, no doubt the result of a previously extended Democratic régime; there is a statue in the Public Garden in Boston neither to Drs. Long nor Morton but, as Oliver Wendell Holmes said, "to Ether one."

In 1845 there was born in Germany a German physicist, who, educated in Holland, studied in Zurich, and finally, after many other appointments, became Professor of Physics at Wurzburg. In 1895, working in his laboratory, he discovered the peculiar properties of electricity in a vacuum tube and found a radiation able to penetrate certain solid substances and affect a photographic plate. He called the radiation "X-ray". Subsequently we called them Roentgen rays after their discoverer. Unfortunately, we again refer to them as X-rays, forgetting the man behind the discovery. On the table is the first printing of this discovery along with a copy of the first X-ray, or Roentgen ray, ever taken. But how time flies, and how many brilliant men have been responsible for our success, and our achievements.

Lest there be some here tonight who will recall a number of those who should be included in the Hall of Fame and whom I have failed to mention, I would say to them again, how time flies, and patience dwindles. Also, my collection is somewhat small, but I wanted to show a few of the outstanding contributions of the men I've mentioned.

Naturally we do not overlook the Curie family, whose first pamphlets are next to the Roentgen rays; and I should have a copy of the first "Becquerel," but haven't. What a pity the son of the Curies is tinged with other rays—the Red rays of Russia.

How can we ever forget the Big Four, Osler, Halstead, Finney and Welch. When I was still a medical student one of our Society, Worth Daniels, gave me one of my first medical books, "Aequinimitas" by Sir William, which I still read and from which I can still learn. There are countless others whose glory shall never die.

Only one more colossus of our times, one of many truly, but one in whom I am especially interested, whose brother was an obstetrician but who himself preferred to work on a higher level of investigation—Dr. Harvey Cushing, brain surgeon extraordinary. His manuscript and life inspired this paper, and it is only fitting that his words should end it.

I quote from him, "There is a pecularity about books, insufficiently emphasized. They are Bibliotrophic, one attracting another; for books don't quarrel, only their authors." But, alas, there is a danger. Listen again to Dr. Cushing: "A friend has been staying with me, whose metabolism and pulse rate in the presence of other people's books run high. He grows exophthalmic with hyperbiblioism. So, while you endeavor to concentrate upon your proper task, he exclaims, 'Where did you get this Dolet Imprint,' holding up a vaguely remembered calf of a book in his hand. 'Oh, I don't remember, someone may have left it at the door.'—'Are you aware,' says he, 'that Christie only knew of one other copy?' This is enough; you are lost, the attack is on, and you want to know about the author, the printer, the time, the book. One may start with a single book written by a single person from which the history of the world may seem to radiate."

"There are, of course, limits to this as to any hobby if you are not cautious, but as a form of relaxation, for a tired and often harassed doctor, it beats golf or bridge, and all outdoors together." And again, "Books may be to the individual doctor the greatest source of relaxation, his greatest solace in time of trouble." And, I must add, one of his greatest joys of all times. *There are no boundaries.*

CALENDAR OF SPEAKERS

The following members of the Medical Society of the District of Columbia have addressed lay groups during the past several weeks. The Society maintains a Speakers Bureau, sponsored by the Committee on Public Relations, through which requests for speakers for lay groups, including radio programs, can be filled.

Date	*Speaker*	*Subject or Title*	*Organization*
January 13	Dr. Addison M. Duval	How to Organize Mental Hygiene Clinics for Public and Parochial Students	District Congress of Parents and Teachers
January 20	Dr. Seymour J. Rosenberg	Psychology of Anti-Semitism	Men's Club, Temple Emanuel, Silver Spring, Md.
January 21	Dr. Robert P. Odenwald	The Child—the Young Adult	Catholic University Campus School Parents' Guild
January 25	Dr. Edward M. Pickford	Discussion and showing of film, "Alcohol and the Human Body"	Public Health Nurses, Alexandria City Health Department
January 25	Dr. Anthony Zappala	Alcoholism and Management of an Alcoholic Rehabilitation Clinic	Staff of Anne Arundel County (Maryland) Department of Health
January 26	Dr. Francis M. Forster	Present Status of Research in Multiple Sclerosis	Washington Multiple Sclerosis Society
January 26	Dr. Benjamin Karpman	The Range of Psychotherapy in a Clinical Setting	Northern Virginia Mental Hygiene Society, Alexandria
January 28	Dr. Sidney Berman	Discussion of film, "Farewell to Childhood"	Montgomery County Mental Hygiene Society, Chevy Chase, Md.
February 4	Dr. I. Phillips Frohman	Tuberculosis—Case Findings in the Older Age Group	American Legion Nurses
February 5	Dr. Julius Schreiber	The Emotionally Healthy Family	Bethesda-Chevy Chase Parents' Study Association
February 9	Dr. Edith Weigert	Conscience as Seen by the Psychiatrist	Unitarian Church Group
February 11	Dr. Edward M. Pickford	Discussion and showing of film, "Alcohol and the Human Body"	Georgetown Nursing Office, District of Columbia Department of Public Health
February 16	Dr. Sidney Berman	The Role of the Woman in the Family	Montgomery County Chapter of the National Council of Jewish Women
February 16	Dr. Reginald Lourie	Teen-Age Years	Unitarian Church Group
February 23	Dr. Julius Schreiber	The Emotionally Healthy Family	Kalorama Mothers' Club
February 25	Dr. Charles Pate	Panel participant, "Whom Do We Serve?"	Friendly Visitors Orientation Program, United Community Services
February 25	Dr. Julius Schreiber	Your Stake in a Mentally Healthy Community	Baltimore Mental Health Society, Baltimore, Md.

On the Lighter Side

On February 25 the first contingent of Mr. Clark Griffith's hirelings speeded to Florida to begin the unlimbering process that will get the creaks and groans out of lazy muscles and joints. The warm semi-tropical sun and the refreshing trade winds will work wonders with aching backs and sore arms and stiff legs. The eager rookies will bloom like the Crocus in the Spring only to fade slowly and surely as the veterans begin to get back into good physical condition.

The exhibition games will reveal the startling evidence that rookie Bob Battum and rookie Phil Fieldum, who came up to the majors with so much promise, play baseball like they have two left feet and mostly thumbs on both hands. That sharp batting eye that elicited reams of sport page praise back in Podunk turns out to be myopic, and those nimble running legs in the minors are lumbering like a livery wagon.

The return to Washington of Mr. Griffith's ball hands next month will mean the final polishing of all rough edges on the athletes who will be in active baseball competition for the coming season. This physical conditioning has taken much valuable training time and much money from the coffers of the Washington Baseball Club. These carefully selected athletes represent a financial value in physical condition and training similar to an investment in a valuable business with a promising future. To protect this investment, Mr. Griffith and the Washington Baseball Club have hired one of the D.C. Medical Society's most capable members to see to it that any injury to the ball player that is real or imaginary be diagnosed correctly and treated properly. Cuts, bruises, contusions, broken bones, slipped disc or a cracked skull, and all the other injuries to which a valuable ball player is subject, is the special domain of the Washington Baseball Club physician. Without his omnipresence on the scene of each home game many a seemingly harmless bruise could well turn into a serious injury to the ball player, thereby preventing his active participation in a crucial game. To prevent such a catastrophe the Club physician must be available at all times.

Prompt attention to all and every physical complaint from the ball player is the team physician's responsibility. It is his good judgment that determines whether the eager outfielder who bumped headlong into the left field fence while chasing a home run ball should retire to the observation ward or go back into the game. It is his good judgment to decide whether or not the complaint of the ball player is based on physical fact or on illusory imagination. The team physician must order X-rays for the suspected broken bone or must operate if need be. He must prescribe and give counsel and be doctor and friend at the same time.

The baseball player is valuable chattel and as such must have efficient and proficient medical care. Mr. Griffith's entity in his investment has predetermined the type of medical care to be afforded his players. He cannot allow to chance the ball player's choice of medical care for accidents or illnesses that develop during the active playing season; therefore, Mr. Griffith supplies his own good medical care paid out of the treasury of the Washington Baseball Club, so that his ball players will be able to perform at their physical best at all times.

One enviable duty of the Washington Baseball Club physician is the compulsory attendance of the physician at every scheduled home baseball game. A box seat, just above the dugout on the Washington side, is reserved for him and an usher sees to it that no one takes squatter's rights if the physician is engaged elsewhere in the stadium. The Club physician may drive his car into the inner sanctum if he so desires and no one will molest it. However, to the Club physician this is just another day's or night's work. There are times when he isn't able to be seated long enough to thoroughly enjoy and follow the game that is progressing excitedly on the playing field. He must be available for the sudden accident to the ball player, but he must be available also to see and examine any fan who might get ill or injured while in the confines of the ball park. The Club physician, after examination of the person ill or injured, will notify the person's private physician, will order an ambulance to take the person to the hospital or to the person's home, but will not treat the person except where emergency treatment is indicated. In this way it is possible to prevent many a serious tragedy, simply by having available at all times a good and competent Club physician.

The Washington Baseball Club physician has had as many as 30,000 prospective patients at one time in his ball park waiting room, any one of which could be a major responsibility at any moment. However, the compensation is well worth the responsibility—he gets to see all the home games for free.

Who is the Washington Baseball Club physician? Why, Dr. George A. Resta, of course!

The strikes and spares have been coming with exciting regularity in the D. C. Medical Bowling League. The top teams have been reluctant to change places with the runners-up, and the Casualty team has established an 8-game lead for first place, but the next 5 teams are bunched with only 2 games separating second place George Washington from sixth place Washington Medical Center. Suburban is third; Sibley ⋇1 and Sibley ⋇2, fourth and fifth; Georgetown is seventh; and Columbia, Prince Georges, Emergency ⋇2, Garfield, Doctors, Emergency ⋇1, the Good Hopers and Providence follow in that order.

The special prize winners for the 6-week period ending February 12, 1954 are as follows: Meredyth Pharmaceutical Co. award to Dr. John P. D'Angelo for high game of 170; District Wholesale Drug Corp. award to Dr. Roy G. Klepser for second high game of 153; and Peoples Drug Stores, Inc. award to Dr. J. W. Price for high set of 386.

J. Earl Kadan, M.D.

THE MEDICAL RESERVE COMPONENTS OF THE ARMED FORCES

Reference is made on the President's Page of this issue to the medical reserves. Below are published the latest data on these components in the Washington area.

Army Medical Reserve

The following USAR medical units are assigned to the District of Columbia Military District:

1. The 805th Hospital Center, whose Commanding General is Brigadier General Frank E. Wilson, MC, USAR, also, the Director, Washington Office, American Medical Association, is one of only 5 Hospital Centers in the United States. The Hospital Center is the major medical reserve command in the DCMD and will serve as such in any area to which it is assigned in case of mobilization. It coördinates and supervises the activities of 3 or more General Hospitals plus any other medical units or nonmedical units as may be attached to the hospital center for operation. This unit meets for training on the first and third Wednesday of each month.

The 805th Hospital Center has been designated the Senior USAR Headquarters by the Commanding General, Second Army, to conduct the annual unit training at Camp Pickett, Virginia from 18 July to 1 August 1954 for the following medical units:

Name of Unit	*Home State*
341 General Hospital	Pennsylvania
354 General Hospital	D.C.-Maryland
361 General Hospital	Pennsylvania
300 Field Hospital	Pennsylvania
810 Conc. Center	Kentucky

2. The 354th General Hospital is a 1000-bed General Hospital and doctors, nurses, dentists, Women Medical Specialists Corps, Medical Service Corps officers and enlisted personnel from the metropolitan area of Washington. The commanding officer of this unit is Colonel Joseph J. Wallace, MC, USAR, who is with Yater Clinic and also a consultant for the Veterans Administration. The 354th General Hospital will participate in the annual unit training at Camp Pickett. This unit conducts a 2-hour professional training program every Thursday evening, 8:00 p.m., at 2123 C Street, N.W. A special program in the very near future for nurses and other personnel will be started. There are presently a number of vacancies for doctors, nurses, and enlisted personnel in the 354th General Hospital. Further information can be obtained by calling Lieutenant George M. Beam, Medical Unit Advisor, phone Sterling 3-5392.

3. The 2939th Medical Unit (Training) is commanded by Colonel Alfred Brigulio, MC, USAR, who is a Clinical Instructor in Medicine, George Washington Medical School, and in private practice of medicine. His Executive Officer is Colonel F. Royce Franzoni, MSC, USAR, who is also the President of the American Pharmaceutical Associ-

ation. This unit is composed of about 40 doctors and other Army Medical Service officers. They have outstanding training programs. Their speakers include many people in high government or private positions. Reserve officers may be assigned to this unit to receive their training for retention in the USAR and retirement benefits. In addition, position vacancies exist in medical companies of line units.

NAVAL MEDICAL RESERVE

The Potomac River Command Voluntary Reserve Company W-1, First Unit. The Commanding Officer of this unit is Captain John A. Reisinger, MC, USNR, 901 20th Street, N.W., Washington, D.C. This unit consists of a mixed group of medical officers, medical service group officers, and nurse group officer, meeting on a voluntary basis twice a month. The second Tuesday at 8:00 p.m. it meets at the District of Columbia Medical Society building, 1718 M Street, N.W., Washington, D.C. The fourth Friday, at 8:15 p.m., it meets at the National Naval Medical Center (Bethesda Naval Hospital). Programs are of general interest to the various branches of the Naval medical program. There are no enlisted personnel in this unit.

Second Unit Potomac River Naval Command Composite Unit W-22. The Commanding Officer is Commander A. C. Cornsweet, Medical Service Corps, 2701 South 8th Street, Arlington, Virginia. It is a reserve group working on various research problems in medicine and allied sciences. There are no enlisted personnel in this unit.

Medical Duty with Nonservice Units. There are 9 nonmedical units in various branches of the Potomac River Naval Command. Each of these units has a medical officer attached for duty therewith. These units are on a pay status. For information concerning these units and medical units in the Potomac River Command, call Lincoln 7–5700, Extension 689.

AIR FORCE MEDICAL RESERVE

The Medical Reserve program with the Air Force is administered by the Continental Air Command. Major Charles A. Herzog is their Liaison Officer for this area.

At the present time there are existing vacancies for medical personnel in the reserve program. Reserve medical units per se have not yet been formed but when sufficient reserve personnel express an interest, Medical Flights comparable to Reserve Hospital Units will be organized and an active program instituted.

A considerable number of vacancies exist for Mobilization Assignees (training with pay) in the Surgeon General's Office and the USAF Hospital, Andrews Air Force Base. Vacancies exist for Mobilization Designees (training without pay) in the Surgeon General's Office and at the USAF Hospital, Bolling Air Force Base.

Reserve USAF Medical Service officers of all corps may become affiliated in a growing organization. Physicians, nurses, allied scientists, dentists and medical technicians will find a program to suit their particular needs in order to earn point credits and retirement benefits.

For particulars concerning the USAF Medical Reserve Program, Major Herzog may be contacted at Extensions 66220 or 63379 at Liberty 5–6700. Particulars concerning Mobilization Designees and Assignees may be obtained from Captain Charles H. Burge, Emerson 2–9600, Extensions 82 or 528.

A.D.A. FORECAST

Physicians throughout the country have found in the A.D.A. *Forecast* a valuable supplement to the teaching which the physician gives his patients in the many problems which arise in the proper management of diabetes.

The A.D.A. *Forecast* is an authoritative publication, held in high regard by physicians and their patients and families. It is edited by Dr. Frederick W. Williams, one of the founders of the American Diabetes Association, and has a distinguished medical Editorial Advisory Board which includes Dr. Charles H. Best, a co-discoverer of insulin.

Subscriptions are available to all at $2.00 a year, $3.50 for 2 years, or $4.75 for 3 years. The *Forecast* is published bimonthly by the American Diabetes Association, 11 West 42nd Street, New York 36, New York.

Sample copies and subscription forms are available without cost to any physician for use with his patients. Many physicians have found it quite valuable to present a year's subscription to each new diabetic patient; the good will engendered has been well worth the nominal cost.

News and Personals

MEETINGS—Past and Future

The American College of Physicians announces 8 Postgraduate Courses for the spring months. Two of these meetings will be held on the Eastern Seaboard. They are:

March 22–26: Selected Subjects in Internal Medicine. Dr. Franklin M. Hanger and Dr. Robert F. Loeb, Co-directors; Columbia-Presbyterian Medical Center, New York.
May 10–14: Internal Medicine. Dr. Francis C. Wood and Dr. Calvin F. Kay, Co-directors; University of Pennsylvania School of Medicine, Philadelphia.

The registration fee for members of the College is $30 and $60 for nonmembers. All registrations must be made through the Executive Offices of the College, E. R. Loveland, Executive Secretary, 4200 Pine Street, Philadelphia 4, Pa.

A meeting has been called for the purpose of organizing a **Washington Chapter of the Jefferson Medical College Alumni Association.** The meeting will be held in the Medical Society's library, Friday evening, March 26, at 8:15 p.m. Dr. Mario Castallo of Philadelphia will address the group. All graduates of Jefferson Medical College are urged to be present.

The Sixth Annual Symposium on Recent Advances in the Study of Venereal Diseases will be held in the auditorium of the Department of Health, Education and Welfare, Washington, April 29 and 30. The topics to be discussed at this Symposium will cover many aspects of venereal disease control including basic and clinical research, serology, epidemiology, treatment, program operation, and professional education. The sessions are open to all physicians and workers in allied professions who are interested in participating.

The Second World Congress of Cardiology and the 27th Annual Scientific Sessions of the American Heart Association will be held in Washington, D. C., September 12–17, 1954. **Dr. Clayton B. Ethridge,** President, and **Dr. Bernard J. Walsh,** immediate Past President, of the Washington Heart Association, are members of the Organizational Committee.

Physicians are invited to submit papers for the program. At least one of the authors must be a member of the Congress, and present the paper. The time allotted for each paper will be strictly limited to 15 minutes. Titles and abstracts of not over 200 words, typewritten, must be received in the office of the American Heart Association on or before April 1, 1954. They should be addressed to Dr. C. D. Marple, Medical Director, 44 East 23rd Street, New York 10, New York, so that they may be evaluated by the Program Committee of the American Heart Association.

The Section on Otolaryngology of the District Medical Society met for its regular bi-monthly meeting at the Army-Navy Club, January 20. Dr. Arnold Friedman, neurologist from New York City, who is in charge of the Headache Clinic of Montefiore Hospital, was the guest speaker; his topic for discussion was "Headache," with special emphasis on migraine headache.

Dr. Lester S. Blumenthal and Dr. Marvin Fuchs, who are in charge of the Headache Clinic at George Washington University Hospital, and Dr. Harold Stevens, neurologist from Georgetown University and Children's Hospitals, were present as guests of the Section.

The Washington, D. C. Chapter of the American Federation for Clinical Research met in the Medical Society's library, February 8. Six scientific papers were contributed, representing research from the National Cancer Institute, George Washington University Hospital, National Heart Institute, Georgetown University School of Medicine and Hospital.

Dr. Roy Hertz, of the National Cancer Institute, Dr. John M. Evans, of George Washington University Hospital, and Dr. Laurence H. Kyle, of Georgetown University School of Medicine, were co-authors for two of the papers presented at this meeting: "Acyclic Menstrual Bleeding Associated with Erythrocytosis," Drs. Stanley Green, Hertz and Evans; "Measurement of Renal Phosphorous Reabsorption in Diagnosis of Hyperparathyroidism," Dr. Marcus Schaaf (by invitation) and Dr. Kyle.

Dr. Irving Henry Leopold, of Philadelphia, was the guest speaker for the dinner meeting of the **Section on Ophthalmology** at the Kennedy-Warren, February 9. Dr. Leopold spoke on "Recent Advances in Ocular Therapy."

The regular quarterly meeting of the **Metropolitan Health Officers' Association** was held at the Washngton Golf and Country Club, January 20. Most of the sessions during the past year have been devoted to Civil Defense, as most public health officials in the various areas are charged with the administration of Civil Defense. At the January 20 meeting, addresses were made by Dr. Robert H. Flinn, Chief Medical Officer of the National Office of Civil Defense; Dr. Henry Huntley, National Medical Officer, with headquarters at Westchester, Pa.; Dr. A. L. Chapman, Jr., Director of Region III, U. S. Public Health Service; and Dr. W. R. Southward, Chief Medical Officer for Civil Defense for the State of Virginia.

The next quarterly luncheon meeting will be held at the Washington Golf and Country Club at 12 noon, Wednesday, April 14.

The District Branch of the American Cancer Society sponsored a one-day training session for volunteers, January 28, in the District Medical Society's building in preparation for their role in helping the Society carry on its service to the community and to cancer patients. This session was the sixth to be conducted for ACS volunteers.

Mr. Frederick P. H. Siddons, President of the District Division, opened the meeting. The principal address was made by Mrs. Lucy R. Milligan, National Director for volunteer recruitment and training of the American Cancer Society. **Dr. Calvin T. Klopp,** Director of the George Washington University Cancer Clinic, discussed the nature of cancer and its diagnosis and treatment; Mr. Joseph W. Leverenz, Executive Director of the D. C. Division, the organization and program of the ACS; **Dr. Murray M. Copeland,** Professor of Oncology, Georgetown University School of Medicine, local professional service and education; **and Dr. Ernest A. Gould,** attending surgeon at Garfield Memorial Hospital, the cancer problem today. Mrs. C. Ashmead Fuller, Vice President of the local division, presided at the meeting.

The Jacobi Society held its regular meeting at the Washington Hotel, February 15. Dr. Jacob Ellis Finesinger, Professor of Psychiatry, University of Maryland Medical School, was invited to address the Society; he spoke on "Psychotherapy and Medical Education."

The Clinical Society of the Diabetes Association of D. C. heard a discussion on "Diabetes in Pregnancy" by a guest speaker, Dr. Joseph Hoet, Professor of Medicine from the University of Louvain, Belgium. Dr. Hoet addressed a dinner meeting of the Society at the Hotel Statler on February 5.

The second annual **Cancer Symposium for nurses,** sponsored jointly by the District of Columbia Division of the American Cancer Society, Graduate Nurses' Association, and the District of Columbia League of Nursing was conducted as an all-day meeting, February 17, in the Terrace Room of the Shoreham Hotel.

"Should a doctor tell his patient that the patient has cancer?" was the topic for informal discussion during a panel on Cancer, Your Patient, and You. **Dr. Calvin T. Klopp,** Director of the George Washington University Cancer Clinic **and Dr. Raymond T. Holden,** Professor of Clinical Obstetrics and Gynecology, Georgetown University School of Medicine, were among the panel members. Moderators for the panel were Mr. Nate Haseltine, scientific reporter for *The Washington Post*, and Miss Lillian Adams, Director of Nursing Service for the D. C. Chapter, American Red Cross.

Dr. Charles Cameron, Medical and Scientific Director of the American Cancer Society, was the luncheon speaker; he discussed "Trends in Cancer Research."

During the afternoon session, **Drs. Roy Hertz,** James Holland, **and Robert R. Smith,** all of the National Cancer Institute, PHS, discussed "Endocrinology," "Chemotherapy," and "Surgery," respectively, in the treatment of cancer.

GENERAL NEWS

The Executive Board of the Medical Society of the District of Columbia, at its regular meeting, February 8, authorized the Editorial Board of the MEDICAL ANNALS to sponsor a House Officers' Essay Contest with prizes to be awarded for the best papers submitted for publication in the ANNALS. An expenditure of $150 for four prizes was authorized.

The Secretary reported to the Board that he had been advised by the firm of Covington & Burling that under the will of Mrs. Mary M. Reichelderfer, who died on August 12, 1953, the Society had been bequeathed, "pursuant to the express wishes and desires of my husband, Luther H. Reichelderfer," the sum of $2,000.

The Directors of the **American Board of Obstetrics and Gynecology** announce that the next scheduled examinations, Part II (oral and pathological), for all candidates will be held at the Edgewater Beach Hotel, Chicago, May 10 to 17, 1954. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examinations.

The Directors wish to express their thanks to all the physicians who proctored the written examinations on February 5. The list of physicians recognized for their services included the name of **Dr. Andrew A. Marchetti,** of Washington, D. C.

George Washington University Hospital has received a grant of $5,000 from the Washington Multiple Sclerosis Society for the establishment of a diagnostic and rehabilitation center for victims of multiple sclerosis. Patients to the center, the first in Washington, will be interviewed and examined by a team of physicians who will recommend medications, physical therapy or other services considered necessary to aid the patient. Patients will also be advised with regard to increased social and economic problems attributable to the disease. However, no direct services will be provided patients by the center; they will be referred to community agencies or to private physicians.

Further information regarding the center may be obtained by calling George Washington Hospital, Sterling 3-7800, extension 576, or the Washington Multiple Sclerosis Society, Decatur 2-2100.

Georgetown University has been awarded a grant of $125,000 by the Raskob Foundation. The grant will cover a 4-year period and is to be used to further medical education and medical Catholic action. It is to be matched with an additional $75,000 raised by the University, so that the total financial outlay in this area will be $200,000.

The funds are to be used as supplemental money to increase the efficiency of medical teaching. Part of the grant is to cover scholarships for students who plan to practice in rural areas, a plan which is designed to help meet one of the most pressing problems of medicine today.

An advisory committee has been appointed to aid in the best utilization of this grant, its membership consisting of Dr. Francis M. Forster, Dean of the School of Medicine, Chairman; Drs. Philip A. Caulfield, Raymond T. Holden, Hugh H. Hussey, and William B. Walsh. Dr. Walsh is Executive Secretary of the Committee.

Construction of a new 350-bed structure for **Providence Hospital** began with formal groundbreaking ceremonies, February 11. The Most Reverend Patrick A. O'Boyle, Archbishop of Washington, turned the first shovelful of earth at 3:30 p.m. preliminary to beginning excavation. The hospital is expected to be completed in about 2 years at a cost of $7,000,000 when fully equipped. The building was designed by architects Faulkner, Kingsbury & Stenhouse and will be constructed by the Charles H. Tompkins Company.

The D. C. Mental Health Association has opened its new office at 2227 M Street, N.W. in space donated by the Health Department's Alcoholic Rehabilitation Clinic. The office will be open regularly on Mondays and Wednesdays.

The Medical Society's Executive Offices have been notified that the name of the **National Homeopathic Hospital** has been changed to **Hahnemann Hospital** and the address to 135 New York Avenue, N. W., Washington 1, D. C. There is no change in organization or location.

PERSONALS

Dr. Winfred Overholser represented the American Psychiatric Association at a meeting of the International Preparatory Commission in Zurich, Switzerland, January 23 and 24. The meeting was called to plan for the next World Congress of Psychiatry, to be held in Zurich in 1957.

Dr. Overholser was invited to attend and address the Governors' Conference on Mental Health, which was held in Detroit, February 8 and 9.

Dr. Harold Jeghers, Professor and Director of the Department of Medicine, Georgetown University School of Medicine, participated in a Postgraduate Course conducted at St. Michael's Hospital in Newark, New Jersey, December 9. He discussed "The Treatment of Congestive Heart Failure."

On December 15 Dr. Jeghers addressed the staff of St. Vincent's Hospital, Worcester, Mass., on the topic, "Problems of Postgraduate Medical Education in a General Hospital."

Dr. Lawrence A. Pyle, Jr. has been appointed full-time Assistant Medical Director of the Chesapeake and Potomac Telephone Company. Dr. Pyle will be responsible for the direction and administration of the Medical Office of the Chesapeake and Potomac Telephone Company and will assist the Medical Director, Dr. R. Lomax Wells, in medical matters pertaining to the four Chesapeake and Potomac Telephone Companies operating in the District of Columbia, Virginia, West Virginia and Maryland.

Dr. Frank E. Wilson, Director of the Washington Office of the American Medical Association, was recently confirmed by the U. S. Senate as a Brigadier General in the Army Medical Reserve, commanding general of the 805th Hospital Center. During World War II Dr. Wilson served on active duty with the Army Medical Corps. His primary assignment was in the European Theater of Operations as Executive Officer of the 807th Hospital Center. He was separated from active service in the rank of Colonel.

Three staff physicians of Georgetown University School of Medicine attended and participated in the Annual Meeting of the Eastern Section, American Federation for Clinical Research, which was held in Boston, Mass., January 4. They were **Dr. Laurence H. Kyle,** Associate Professor of Medicine; **Dr. Charles E. Rath,** Assistant Professor of Medicine; and Dr. Edward A. Partenope, Fellow in Medicine.

Dr. Kyle was elected Chairman of the Eastern Section for the current year. A paper entitled, "Intermittency of Flow in Larger Vessels of the Human Forearm" was read by Dr. Partenope at this meeting. Co-authors of the paper were **Dr. Edward D. Freis** and Dr. Lawrence S. Lilienfield.

Dr. Hugh H. Hussey, Professor of Preventive Medicine and Public Health at Georgetown University School of Medicine, addressed the Buffalo Academy of Medicine in Buffalo, New York, January 27. He spoke on "Emotional Problems of Adolescents."

Dr. Edward D. Freis, Associate Professor of Clinical Medicine, Georgetown University School of Medicine, addressed the Regional Meeting of the American College of Physicians in Baltimore, January 16, on the subject, "Clinical Experience with the Use of Pentapyrrolidinium in the Treatment of Hypertensive Patients, with Particular Reference to Combinations with Other Agents." Dr. Lawrence S. Lilienfield and Dr. Edward A. Partenope, Fellows in Medicine at Georgetown, were co-authors of the paper.

Dr. Harold Jeghers, Professor and Director of the Department of Medicine at Georgetown, addressed the meeting the same day on "Macroglossia; a Clue to the Diagnosis of Systemic Disease."

Dr. Julius S. Neviaser, Assistant Clinical Professor of Orthopedic Surgery, George Washington University School of Medicine, gave an instructional course lecture, January 27, during the meeting of the American Academy of Orthopaedic Surgeons, which was held at the Palmer House in Chicago, January 23–28.

Dr. Milton C. Cobey presented his exhibit, a study of the use of plastics in arthritic joints, at the same meeting. Dr. Cobey's exhibit is currently on display at Georgetown University School of Medicine, where he is Associate Professor of Orthopedic Surgery.

Dr. Zigmond M. Lebensohn addressed the Albemarle County Medical Society in Charlottesville, Va., on February 4. The subject of his address was "Problems Encountered in Medical Referrals to Psychiatrists."

Dr. Thomas F. McDermott, Professor of Anesthesiology, Georgetown University School of Medicine, addressed the Anesthesiology Staff of Columbia Presbyterian Medical Center in New York City, February 11, on "Congenital Heart Disease."

Dr. Bennett Olshaker, pediatrician, participated in a panel discussion on Preparing the Preschool Child for Better Dental Health, which was presented at the Shoreham Hotel on National Children's Dental Health Day, February 1. Dr. John A. O'Keefe, of the D. C. Dental Society, summarized the discussion.

Dr. Lloyd G. Lewis, Clinical Professor of Urology at Georgetown University School of Medicine, has been elected an alumni representative to the Hamilton College Board of Trustees in Clinton, New York. He will serve for 6 years beginning July 1.

Dr. John A. Reed attended the Mid-year Council Meeting of the American Diabetes Association and Postgraduate Course given by the Association in Rochester, Minn., at the Mayo Clinic, January 14–18. Dr. Reed is Secretary of the A.D.A.

Dr. Henry R. Lyons returned to Washington on January 1 after having completed a three-year residency in psychiatry at the Mayo Clinic, Rochester, Minn. Dr. Lyons is affiliated with Georgetown University School of Medicine as Assistant Professor of Psychiatry.

Dr. Robert E. Moran has resigned as chief surgeon for the Washington Redskins, a position he has held for the past 16 seasons.

Dr. Joseph C. McCarthy is now living in Springfield, Mass. His address is 26 Mulberry Street.

Dr. Thomas M. Foley has moved to California. His address is 3000 Second Avenue, San Diego.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, February 1, 1954, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society.

Active Members

William H. Bullock, 408 T Street, N.W.
Owen Gwathney, 901 23rd Street, N.W.
Donald McC. Harper, 1915 New Hampshire Avenue, N.W.
David W. Harris, St. Elizabeths Hospital
Robert L. Krichmar, 12414 Dalewood Drive, Silver Spring, Md.
Cyrus H. Maxwell, 1523 L Street, N.W.
Kline A. Price, 109 Rhode Island Avenue, N.W.
James E. Swan, 213 Florida Avenue, N.W.
Robert H. Syme, Jr., 1717 N Street, N.W.
Bertha E. Van Gelderen, 1025 Connecticut Avenue, N.W.
William H. Wallop, 1219 16th Street, N.W.
Emerson A. Williams, 1206 Kenyon Street, N.W.

Associate Members

W. Marion Falls, D.D.S., 4320 Verplanck Place, N.W.
Robert M. Greenberg, 8641 Colesville Road, Silver Spring, Md.
Errol Nicholson Harding, 3800 Reservoir Road, N.W.
Robert John Lukes, 306 North Lincoln Street, Arlington, Va.
Robert H. Parrott, National Institutes of Health, Bethesda, Md.
Ergi J. Pesiri, U. S. Coast Guard Headquarters, 1300 E Street, N.W.
J. Herbert Smith, Veterans Administration

Dr. Melvin G. Alper, Hospital University of Pennsylvania, Philadelphia 4, Pa., was elected to Active membership at the meeting of the Executive Board, December 28, 1953.

CORRESPONDENCE

Washington, D. C., January 25, 1954

To the Secretary of the Medical Society of the District of Columbia

Dear Mr. Wiprud:

In reference to your letter requesting that the administration of each voluntary hospital in Washington set aside one medical bed for emergency cases, the following is offered.

The Council expressed the belief that the problem of obtaining admission for patients seriously in need of hospital services is of little consequence in that the hospitals' doors are never closed to the public in need of emergency treatment. Also, as to the aspect of actual administration, it would not be feasible to keep even one bed empty or set aside for a specific use. The hospitals will continue to accept all emergency type patients for treatment and only in the event of extreme overcrowding will they request that the patient be moved elsewhere for continued inpatient treatment.

In several instances in our teaching institutions a bed may be reserved for a specific use, but these may be classified in the category of teaching material of specialty classification and it is found that this reserved bed is continually in use, having both planned and specialty type patients. The planned inpatient is moved to a regular inpatient bed when the need for the specialty bed arises.

It was felt that a physician having the problem of placing emergency cases direct his complaint directly to the administrator of the hospital concerned.

I would be glad to follow this matter further if the Committee on Medical Care or Dr. Lichtman feels it would help resolve their problem.

Sincerely yours,
W. M. Bucher
Executive Secretary, The Hospital Council of the National Capital Area

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Washington, D. C., January 25, 1954

To the Editor:

Your editorial, "The Retarded Child and His Family," in the December 1953 issue, informative about the need for community facilities and services to which physicians can turn for help with problems of retarded children, was discussed at the last meeting of the Board of Directors, Help for Retarded Children. The Board, of which I am a member, requested me to reply with appreciation for your recognition of the need for closer liaison between the medical profession and organizations, such as itself.

Help for Retarded Children began in the District four years ago as a group of parents face to face with common problems. They needed help from each other to gain insight into their own emotional difficulties about their children; to find constructive, concrete things to do to further the training and personality development of their children. The local organization now has about 400 active members, not all of them parents. Many are persons and representatives of organizations moved by a spirit of sympathy and helpfulness, a source of strength to the parents. The local organization is linked to the National Association for Retarded Children, formed only three years ago; already it has strong local support and active committees on Education and Research. The national organization is a truly "grass roots" development, springs from real local needs.

The local organization has already been of impressive educational importance to parents, given them opportunities to work through with each other the frustrating feelings of guilt and impotence, opportunities to work with each other on constructive projects: The Sunnyday School for Retarded Children, special classes for retarded children in Montgomery County and the District schools, parent meetings with practicing psychiatrists and personnel of the district Health Department, selection of literature for parents, showing of selected movies, liaison with other organizations.

The Board was pleased to see your reference to Dr. Grover F. Powers, distinguished pediatrician of New Haven, Connecticut, a powerful friend and influential contributor to the scientific understanding of retarded children and their families. We were glad to learn (Pediatrics: Vol. 12, No. 2, August 1953) of his award by the American Pediatric Society, May 1953, of the John Howland Medal for outstanding service to pediatrics.

The Board would like to invite pediatricians, psychiatrists, and other practicing physicians to refer parents of retarded children to HRC; physician or parent may call Mrs. Ralph Orcutt (Tel: LUdlow 1-6797) for information. HRC is presently assembling available information about other agencies and services for retarded children, a clearing house function. It would appreciate assistance from the medical profession in making the information complete.

HRC stands ready to assist and offers its services to the medical profession, hopes for a mutually satisfying relationship.

Sincerely yours,
John A. Lewis, Jr., M.D.
Regional Mental Health Consultant, Department of Health, Education, and Welfare

BOOK REVIEWS

Fundamental Psychiatry. John R. Cavanagh, B.S., M.D., F.A.C.P., K.S.G., Diplomate of the American Board of Neurology and Psychiatry; Special Lecturer in the School of Sacred Theology and in the Department of Psychology, Catholic University of America; Member of the Commission of Mental Health, District of Columbia; Associate Clinical Professor, Georgetown University Medical School; Former Lecturer in Psychiatry, National Catholic School of Social Service; Former Commander, Medical Corps, United States Navy; and James B. McGoldrick, S.J., S.T.D., Ph.D., Professor and Head of the Department of Psychology, Seattle University. Price, $5.50. Pp. 582. Milwaukee: Bruce, 1953.

The authors have presented the material in a clear, concise, simplified and well-organized manner. The chapters on Clinical Psychiatry are well presented with especially good case histories. Each chapter is nicely outlined, presented in simplified form, with exceptionally good definitions. They have emphasized the fact that in the toxic somato psychic psychoses the symptoms (subjective manifestations) are the result of the patient's reaction to his disease and are based on his pre-psychotic personality (superimposed or functional component), and the signs (subjective manifestations) are based on organic disease of the nervous tissue. Recognition of this fact is necessary for a complete evaluation of the psychopathology. The psychogenic factor in the alcoholic psychosis is overly stressed, particularly with reference to delirium tremens and Korsakoff's psychosis.

The book differs from the usual text on Clinical Psychiatry in that approximately one third of the material is devoted to the origin of mental illness with philosophical orientation and consideration. The dualistic, mind-body approach to mental abnormalities is preferred to the materialistic point of view and rightly so. The application of philosophical and religious values and principles to psychiatry at the clinical level has been achieved.

Considerable discussion is centered on the repressed unconscious of Freud in the authors' concept of marginal repression. The repressed unconscious of Freud is not dynamic and cannot account for motivation that leads to activity, whereas the marginally repressed conflict is dynamic and suffices for motivation. The authors completely deny the existence of repressed conflicts totally removed from awareness (repressed unconscious of Freud) as a cause for dynamic action and influencing conduct. This reviewer cannot subscribe to this concept. Behavior is determined by a combination of forces operating at the unconscious as well as the conscious level. Much of the repressed material is not only out of focal awareness but the individual is incapable of recalling and this may form the basis for the motivation of pathologically directed drives influencing acting, feeling and thinking processes accounting for human conduct. This concept can still be psychologically and philosophically sound while at the same time rejecting Freud's deterministic theory and his denial of free will.

A truly positive approach in the therapeutic relationship is evident. Emphasis is placed on the rational and spiritual approach to the problem. Encourage the development of a positive life that includes a well directed goal, proper sense of values, spiritual orientation, evaluation of the potential assets of the individual, and encourage the capitalization of same.

The authors in the chapter on Psychopathic Personality point out that there is no uniformity of opinion with regard to the legal responsibility of the psychopath. It might be well to point out that the consideration of the qualitative and quantitative factors of responsibility would help clarify this situation. We should be interested in responsibility from the moral, ethical and social, as well as the legal phase, and in terms of degree depending upon the true capacity of the individual. With respect to right or wrong as it now stands it must be either black or white. This is no true measure of responsibility. A modification of these two extremes in terms of degree with the consideration of various shades of gray would seem a more judicious approach.

The book should prove invaluable to the student as a textbook on clinical psychiatry to which has been added philosophically directed goals with definite therapeutic values.

F. Regis Riesenman, M.D.

Diseases of Metabolism; Detailed Methods of Diagnosis and Treatment, 3rd ed. Edited by Garfield G. Duncan, M.D., Director of Medical Division, Pennsylvania Hospital; Clinical Professor of Medicine, Jefferson Medical College, Philadelphia, Penna.; with 20 contributors. Price, $15.00. Pp. 1179, illustrated. Philadelphia: Saunders, 1952.

The third edition of this well-known textbook has been revised and new material added so that the merit and value of the second edition have been perpetuated and enhanced.

The wide scope of medicine covered can be adequately appreciated only by a careful appraisal of the Table of Contents. The caliber of the contributing authors will ensure this publication a preëminent place among volumes dealing with metabolic disease.

This book has two outstanding features to both practicing and laboratory physicians: first, it is essentially an academic textbook presenting its knowledge in a factual and basic manner; second, it is an excellent source for rapid reference, and it is this which should ensure its placement in the library of all doctors.

The physiology and mechanisms underlying disease processes, often neglected, or at best but briefly discussed in most medical texts, are given here proportional discussion and proper perspective. Succinctly, the subject matter is lucid and comprehensive because a disease is considered as affecting the whole functional organism, and all its facets are discussed in their proper relationship, one to the other.

The preparation needed for each subject can be appreciated by a glance at the references terminating each chapter.

The section on diabetes, as in the previous edition, is excellent. Carbohydrate metabolism is discussed at great length, yet practical applications of the content are abundant. Many of us are reminded of the fact that it is the evening urine specimen which is more likely to reveal glycosuria and thus initiate the search for diabetes. The assertion is made that the Test Meal is a more reliable test than the more commonly used and certainly more expensive Glucose Tolerance Test. The two-hour postprandial blood specimen should be used in lieu of the commonly ordered fasting blood sugar. Of particular value to the student and practicing physician are the discussions of diabetes in pregnancy, the control and treatment of diabetic complications, and a comprehensive list of applicable diets. A separate chapter deals with the many problems pertinent to diabetes in childhood.

The section dealing with thyroid diseases includes a lengthy discussion on the therapeutic and diagnostic use of radioactive iodine. The value of using aqueous adrenal extract in "thyroid storm" is indicated.

A more detailed discussion of the artificial kidney including diagrams would be a valuable adjunct to the chapter on Kidney Diseases. It is pointed out that the Kimmelstiel and Wilson renal complication will become one of the major causes of death in diabetes, since most diabetics today have a longer life span than 15 years. The full-blown nephrotic syndrome occurs in only 6 per cent of cases of the Kimmelstiel and Wilson syndrome.

A new section on Porphyrin Metabolism has been included in this edition. This rather complicated field of medicine is discussed in a very lucid manner by Dr. C. J. Watson. Porphyria, a frequently misdiagnosed and misunderstood disease, is discussed and color plates included to facilitate diagnosis.

Mention must also be made of the chapters on Mineral Metabolism and Water Balance. Almost 200 pages are devoted to these subjects, which serve as adequate testimony to their ever-increasing importance in medicine.

This book can be thoroughly recommended to all engaged in the practice and study of medicine.

RAYMOND R. STRANG, M.D.

Therapeutics in Internal Medicine, 2nd ed., completely revised and reset. By Eighty-four Authorities. Edited by FRANKLIN A. KYSER, M.D., F.A.C.P., Assistant Professor of Medicine, Northwestern University Medical School, Chicago; Attending Physician, Evanston Hospital, Evanston, Illinois. Price, $15.00. Pp. 830. New York: Hoeber, 1953.

This is a thoroughly revised second edition with 84 contributors, many nationally known. It is a comprehensive text with complete practical descriptions. Wherever necessary, etiologic, physiologic, pathologic, and historic considerations pertinent to current therapy are given. In the opinion of this reviewer, the text rates high with regard to completeness, but it rates poorly as a quick reference source for the busy practitioner.

GEORGES F. MCCORMICK, M.D.

Films in Psychiatry, Psychology and Mental Health. ADOLF NICHTENHAUSER, M.D., MARIE L. COLEMAN, AND DAVID S. RUHE, M.D., Medical Audio-Visual Institute of the Association of American Medical Colleges. Price, $6.00. Pp. 269. New York: Health Education Council, 1953.

"This book is a catalogue and study of representative films, intended to encourage the appropriate use of films in psychiatry, psychology, and mental health." This statement appearing in the opening pages of this useful volume provides an accurate forecast of what is to follow.

For the past 56 years medical men have utilized the film medium, first as an aid to medical teaching, later as a tool in research, and finally as a technic in public education. It is interesting (and, to this reviewer, gratifying) to note that two neurologists, Schuster in 1897 and Marinesco in 1898, were the pioneers in this field. They made their first films of neurologic disorders and gait disturbances in Germany and Roumania just a year after the first public showing of motion pictures. Since then, with the advent of sound and color, our technics have been vastly improved and the problems of making a first-rate teaching film have become correspondingly more complex. As a result, the new films, with rare exceptions, are the result of serious interdisciplinary efforts. Such efforts are so involved and costly as to require sponsorship by either nonprofit agencies such as the U. S. Public Health Service and the various branches of the armed forces, or various commercial film producers. In recent years the National Film Board of Canada and the Mental Health Film Board of this country have sponsored several outstanding films. Despite these advances, it is the authors' thesis that the possibilities of psychiatric films have just begun to be realized.

The body of the book is comprised of 51 critical analyses of films which have been released up to January 1953. There is also a brief description of 50 additional films in this field. Each review is so organized that a careful reading should, in most instances, eliminate the necessity for reviewing the film itself before deciding as to its usefulness. Each review follows a uniform pattern. First, a brief opening résumé quickly describes the content. Next appears data as to the audience for which the film is intended, details of production (running time, type of film, year produced, country of origin, sponsors, supervisors, etc.), and description of any accompanying material to aid the discussion leader. Most practical is the inclusion of details of distribution, including the address of each distributor and the cost for rental or purchase. This is followed by several pages of detailed description as to content, appraisal, presentation, effectiveness, and finally utilization of the film itself.

To those who have seen a sizable number of these films the reviews will appear most accurate and fair. The appraisals of the famous Army film, "Let There Be Light," or the more recent productions of "Angry Boy," "Breakdown," and "Feeling of Rejection," were unusually informative and well written.

This book should become the *vade mecum* of all physicians and especially psychiatrists who are active in community groups or teaching. It will also be of great use to the program chairman of any P.T.A., church organization, or other group interested in promoting mental health by audio-visual aids.

ZIGMOND M. LEBENSOHN, M.D.

May's Manual of the Diseases of the Eye for Students and General Practitioners, 21st ed., revised and edited by CHARLES A. PERERA, M.D., Associate Clinical Professor, College of Physicians and Surgeons, Columbia University, New York; Attending Ophthalmologist, Presbyterian Hospital, New York. Price, $6.00. Pp. 512, with 378 illustrations, including 32 plates, with 93 colored figures. Baltimore: Williams & Wilkins, 1953.

The impressive number of editions of this well-known textbook on Diseases of the Eye testifies to its continuing and widespread popularity.

The contents have been revised in this new edition, and color plates of excellent quality have been included. I believe, however, that they are insufficient in number and that the text would be greatly improved by the addition of many more plates. These could be substituted for the many operative descriptions which are clearly beyond the scope of both students and practitioners. This is particularly true in the sections dealing with diseases of the retina and choroid where further plates illustrating myopia, syphilis, tuberculosis, congenital anomalies and the blood dyscrasias, etc., would enhance the teaching value of those already included.

In the therapeutics of many ocular inflammations, too little emphasis has been given to the antibiotics and cortisone. As a broad generalization, however, the described and recommended treatments will be found of considerable value to the practicing physician. An excellent chapter dealing exclusively with ocular therapeutics has been included.

A very comprehensive list of diseases which produce secondary changes in the eye has been included in a separate chapter. A careful perusal of this list would impress on all readers the helpful clues to diagnosis which can be obtained by the regular use of the ophthalmoscope. Brief discussion is given to most of the diseases, and color plates to illustrate the described phenomena would be a useful addition.

In view of the widespread use of the Keith and Wagener classification of hypertensive retinopathy, space should be found for its inclusion in the next edition.

The original author has succeeded in his aim to produce a volume sufficiently comprehensive, up to date, and yet of limited size to justify its recommendation as a very useful addition to the library of students and general practitioners.

RAYMOND R. STRANG, M.D.

Visceral Circulation. A Ciba Foundation Symposium. G. E. W. WOLSTENHOLME, O.B.E., M.A., M.B., B.CH., Editor for the Ciba Foundation. Assisted by: MARGARET P. CAMERON, M.A., A.B.L.S., AND JESSIE S. FREEMAN, M.B., B.S., D.P.H. Price, $6.50. Pp. 278, with 72 illustrations. Boston: Little, 1953.

No medical school or national organization could ever hope to prepare and organize such a thorough and authoritative program as the Ciba Foundation has done in its three-day conference on Visceral Circulation. Each speaker is a world authority, presenting data from his own laboratory or based on his wide clinical experience.

Divided into four sections, the program follows in logical sequence. The anatomic aspects are presented first, general factors in blood flow regulation next, specific factors in regional blood follows, and finally the interrelation of the general and visceral circulation are presented. Of particular value are Dr. Burton's exposition of Poiseuille's law and its application in human hemodynamics, Dr. Gregg's presentation of aortic and coronary blood flow, Dr. Bradley's presentation of renal and hepatic hemodynamics, Dr. Sharpey-Schafer's discussion of the importance of vasoconstriction in the normal and failing circulation, and Dr. Edholm's presentation of the physiologic changes during fainting.

Each presentation is followed by lively discussion and speculation. The editors have grasped the informality and intimacy of the meeting, thus presenting very readably much information not readily available elsewhere.

The book is well printed on excellent paper. It is the most thorough and lucid volume on the subject that this reviewer has seen and is to be highly recommended to all interested in cardiovascular research or renal physiology.

FRANK FINNERTY, M.D.

WILLIAM NORMAN GADOL, A.B., M.D. (1918–1954)

Dr. William N. Gadol, an Associate member of the District Medical Society, died suddenly, January 17, 1954, at his home, 8404 Bradmoor Drive, Bethesda, Md. He had practiced in Bethesda since July, 1950.

Dr. Gadol was born in Brooklyn, New York, April 14, 1918, the son of Pierre Leon Gadol, who survives him, and the late Eleanor Burchel Gadol. He graduated trom Brooklyn College in 1940 with the degree, Bachelor of Arts. He studied at Georgetown Law School for a year and afterward was Special Agent for the FBI for five years in Springfield, Ill., Covington, Ky., Brooklyn and Syracuse. In 1948 he received his medical degree from the University of Syracuse. He interned for a year at George Washington University Hospital; the following year he was Assistant Surgeon at the Marine Public Health Hospital in Baltimore.

Dr. Gadol was associated with Dr. Leo I. Donovan in offices at 8016 Old Georgetown Road, Bethesda.

He was a member of the American Medical Association, the Montgomery County Medical Society, and an Associate member of the District Medical Society since 1951.

Surviving are his wife, Mrs. Martha Irwin Gadol; two children, William N., Jr. and Barbara Eleanor; and his father, who reside at their home in Bethesda. A brother, Pierre Andre Gadol, lives in Greenbelt, Md.

Pentylenetetrazol and Pentobarbital Sodium Combinations—Fazekas et al

(*Continued from page 136*)

The doses used were from 13 to 20 times the usual human sedative, hypnotic dose. Nausea and vomiting occur in a substantial majority of the subjects.

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Therapy in Epilepsy—Forster

(*Continued from page 141*)

of Law. This committee now operates under a grant from the United States Public Health Service and is making a Nation-wide survey of the laws of the land regarding epilepsy and hopes to frame ideal laws. If the two great professions of law and medicine combine their prestige and enthusiasm behind a move of this kind, a far more rational approach will evolve with the greatest good for the greatest number of people.

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Acne Vulgaris—Osbourn

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Overconcern with Health—Laughlin

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"Little Learning—with Illustrations"—Observer

(*Continued from page 162*)

is a way of ending the wrong kind of popularization." She recommends that "publishers and publishers, editors and editors, writers and writers, make gentlemen's agreements among themselves never again to distort 'This is so' into 'This is it!' or to fan cool facts into hot news. All of us, no worse off competitively than we are now, ought to eat as well—and we would sleep better!"

T. W.

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FUNCTIONAL UTERINE BLEEDING*

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THE MANAGEMENT of functional uterine bleeding has long been subjected to trial and error, attended by varying degrees of success. The management of this common condition need no longer be one of chance success if the simple lessons to be learned from the study of the physiology of normal menstruation are applied to treatment of functional uterine bleeding. Figure 1 illustrates the pituitary-ovarian-endometrial relationships in normal ovulation. It should be remembered that associated with normal menstruation is nearly complete shedding of the endometrium. This is a chemical curettage brought about by sudden withdrawal of hormonal (estrogen and progesterone) support of the endometrium. Figure 2 illustrates the pituitary-ovarian-endometrial relationships in anovulatory bleeding. Accompanying atresia of the graafian follicle there is a

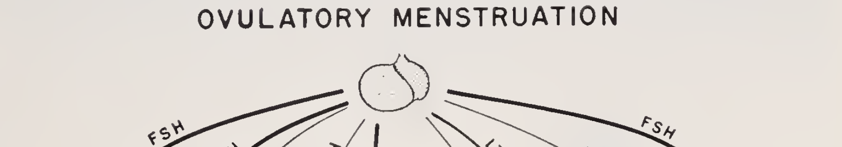

FIG. 1. Pituitary-ovarian-endometrial relationships in normal ovulation (reproduced from Greenblatt[1])

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* Delivered at the 24th ANNUAL SCIENTIFIC ASSEMBLY of The Medical Society of the District of Columbia, October 5, 1953.

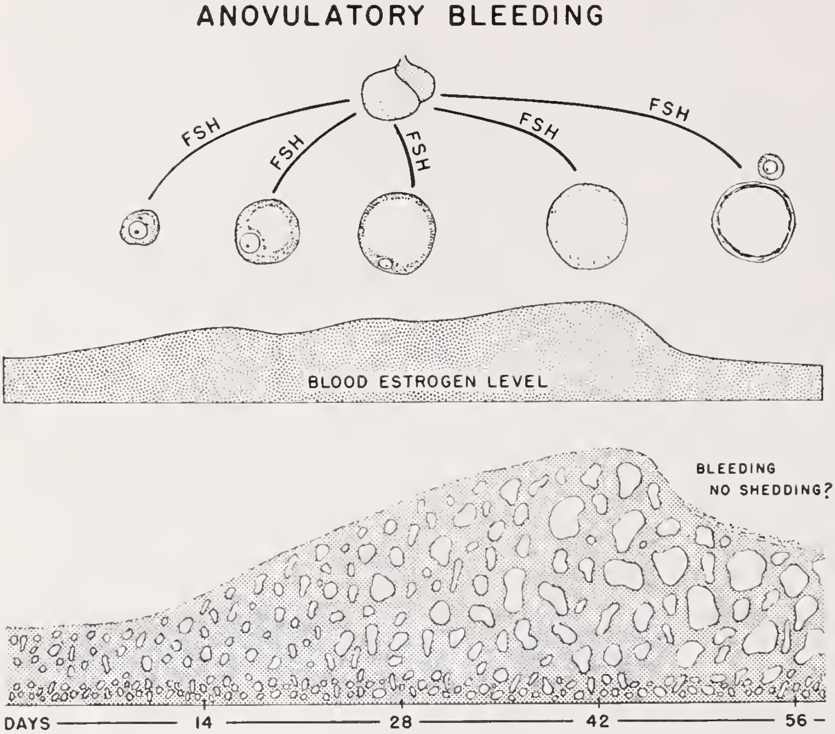

FIG. 2. Pituitary-ovarian-endometrial relationships in anovulatory bleeding (reproduced from Greenblatt[1])

lowering of estrogen levels and the bleeding that results is due to loss of estrogen support of the endometrium. Such bleeding is attended by incomplete or very slow shedding of the endometrium. The raising of the estrogen level by administration of estrogens will bolster the estrogen support of the endometrium and frequently bleeding will cease, while progesterone administration will permit of estrogen and progesterone support which, when withdrawn, will induce a chemical curettage.

The successful employment of hormonal therapy in the management of functional uterine bleeding permits a broader view of the problem and allows for a more liberal definition than that held in the past. Functional uterine bleeding may be defined as abnormal and excessive bleeding which occurs because of physiologic disturbances

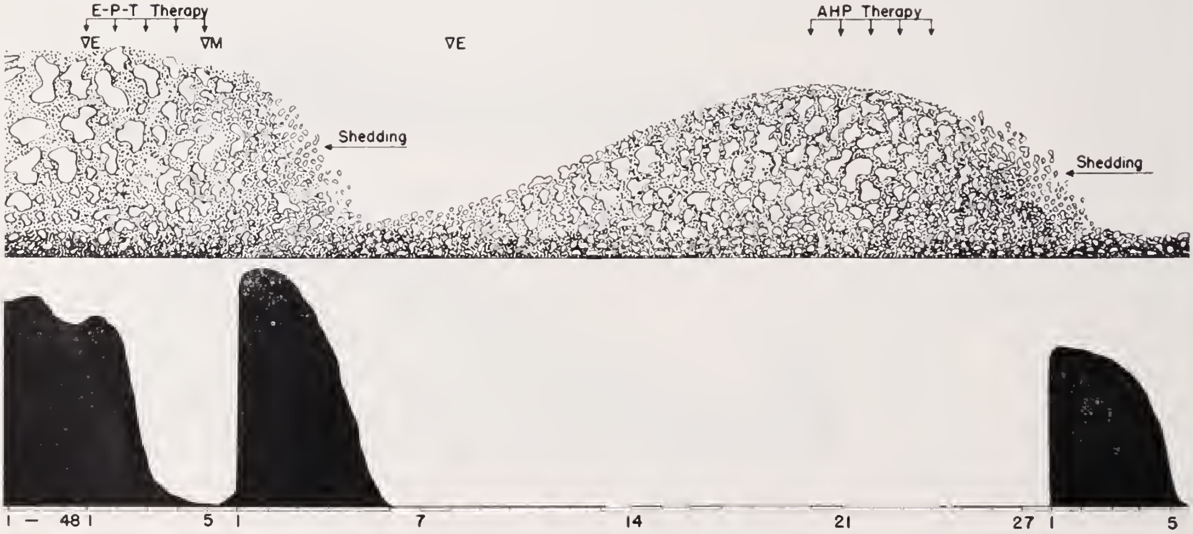

FIG. 3. Arrest of bleeding according to plan.

This is possible if 1 unit, which contains 6 mg. of estrone, 25 mg. of progesterone, and 25 mg. of testosterone propionate, is given for 5 consecutive days. Bleeding will stop within 6 to 36 hrs. Withdrawal bleeding will follow about 48 hrs. after cessation of therapy and this will simulate a normal mensis. Anhydrohydroxyprogesterone (30 mg. orally per day for 5 days) should be given from the twenty-first to the twenty-fifth days of the new cycle to prevent a recurrence of prolonged hemorrhage. (Reproduced from Greenblatt.[2])

and not pathologic processes. Hormonal dysfunction is the chief cause, but nutritional factors, vitamin deficiencies, and nervous and psychogenic factors play important and contributory roles. Bleeding associated with pathologic lesions such as endometrial polyps, pelvic inflammatory disease, endometriosis, and to a great extent, fibromyomata of the uterus, may no longer be excluded, since bleeding in such instances may be brought under control in a manner similar to that employed in purely functional disturbances. Pathologic factors for bleeding which do not and cannot be expected to respond to hormonal therapy are cervical polyps, cervical cancer, uterine malignant lesions, carcinoma of the fallopian tubes, ectopic pregnancy, misconceptions, and blood dyscrasias.[1]

Experience with the use of gonadal steroid hormones in therapy of various gynecic disorders has crystallized sufficiently to warrant certain categorical statements in so far as they pertain to the phenomenon of uterine bleeding.[2,3]

1. Estrogens have been employed successfully for those in whom the uterine bleeding occurred from a cystic glandular hyperplasia or a persistent estrogenic endometrium.

2. Progesterone has been successfully employed for those in whom the uterine bleeding occurred from an imperfect progestinal or mixed type of endometrium, as well as for those with an estrogenic endometrium.

3. Testosterone has been successfully employed for those in whom bleeding was associated with uterine fibromyomata, adenomyosis, or endometriosis.

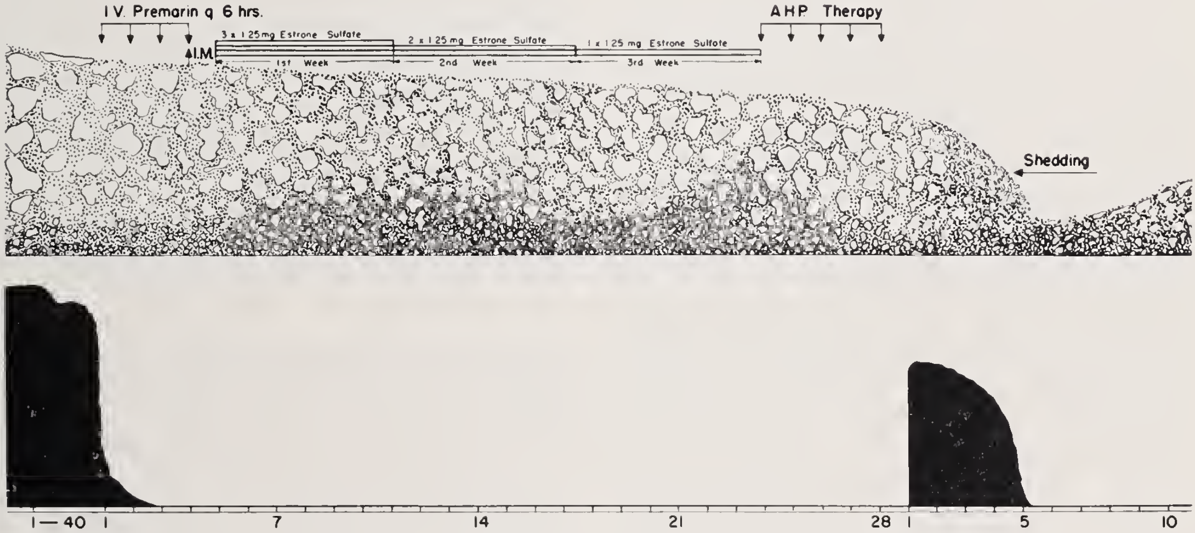

FIG. 4. Intravenous estrogens for the arrest of uterine bleeding.

Bleeding is rapidly arrested if 20 mg. of Premarin (I.V.) is administered intravenously q 4–6 hrs. for 2 to 4 doses, followed by an intramuscular injection of 20 mg. Premarin (I.V.) and oral therapy is begun as follows: Estrone Sulfate tablets 1.25 mg. (or its equivalent) one t.i.d. for the first week, one b.i.d. for the second week, one daily for the third week, after which tablets of anhydrohydroxyprogesterone, 30 mg. per day for 5 days, are administered. A normal withdrawal period usually follows. This method is preferable in adolescent cases and in those patients in whom it is desirable to delay the withdrawal period as long as possible.

The administration of a combination of gonadal steroids containing 6 mg. of estrone or its equivalent (1.66 mg. estradiol benzoate), 25 mg. progesterone and 25 mg. testosterone, will take care of functional bleeding due to various causes in about 95 per cent of all cases (fig. 3). The combined gonadal steroid therapy administered over a period of 5 days usually results in arrest of bleeding within 6 to 48 hours. Withdrawal bleeding that simulates a normal menstrual period (sometimes excessive during the first 2 days) will ensue from 2 to 7 days after cessation of therapy. Although combined estrogen and progesterone therapy is satisfactory in most cases, the addition of testosterone seems to decrease the amount of withdrawal bleeding. Some 20 days later, a course of oral progesterone for buccal absorption (50 mg. per day for 5 days), or pregnenolone for ingestion (30 mg. per day for 5 days), or progesterone by intramuscular injection (10 mg. daily for 3 days), may be administered to induce another withdrawal period. This progesterone therapy may be carried on at monthly intervals until it is established that cyclic ovulatory menses have begun to take place.

A second method of therapy is the use of intravenous estrone sulfate.[4] This is of particular value in young girls and in those women in whom bleeding is acute and the patient exsanguinated. In such cases it is best to delay the withdrawal period for several weeks. It is advisable to use intravenous estrogen every 4 to 6 hours until bleeding is arrested. After initial arrest of bleeding, oral estrogens in decreasing doses over a period of 25 days are administered, and a withdrawal period will thus be delayed until the patient has had an opportunity to recover her balance (figure 4).

Care must be exercised in the selection of patients, since moderately good, though temporary, results may also be obtained in patients with ectopic pregnancy and in cases of bleeding due to endometrial carcinoma. Dilatation and curettage should be performed in all those patients in whom there is the slightest suspicion of malignancy, in all patients approaching or beyond the menopause, and in those who fail to respond satisfactorily to a course of therapy. In young girls and in those women who have had a curettage or repeated curettage in the immediate past, it should not, as a rule, be necessary to perform this procedure.

SUMMARY

For the treatment of functional uterine bleeding, 2 methods of therapy are advanced. Both yield a very high percentage of success (table 1).

TABLE 1

*Therapy of Functional Uterine Bleeding**

METHOD	COURSES OF THERAPY	SATISFACTORY	FAILURES	SUCTION CURETTAGE PERFORMED
I.V. Premarin........	63	52	11†	33
E.P.T...............	60	58	2	30

Not included in this series are:

3 cases of endometrial carcinoma ⎱ unsatisfactory
2 cases of ectopic pregnancy ⎰ response
8 cases of incomplete abortion—satisfactory response in 4

* Reproduced from Greenblatt and Barfield[3]

† Therapy, by later standards, was inadequate in 6.

Should failure be encountered with one method, as it occasionally is, the physician may resort to the other method.

Grateful acknowledgment is made to Wyeth, Inc., Philadelphia, Pa., for a grant-in-aid of research and for supplies of Tristerone used in this study (1 c.c. of Tristerone containing 6 mg. estrone, 25 mg. progesterone, 25 mg. testosterone), and also to Ayerst, McKenna and Harrison, Ltd., New York, N. Y., for a grant-in-aid of research and for supplies of Premarin, Injectable (5 c.c. vial containing 20 mg. conjugated estrogens [equine]).

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CLASSIFICATION OF OVARIAN TUMORS

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A CLASSIFICATION of ovarian tumors is here presented which meets practical teaching needs. Its chief virtue is simplicity. Medical students appear to understand it readily. I believe the average physician who engages in abdominal surgery will find it comprehensible within his own experience. It is flexible enough to encompass every tumor of the ovary in one of the 10 categories listed. Each class is discussed in some detail.

CLASSIFICATION

1. Physiologic:
    Follicle cyst; lutein cyst; corpus luteum hematoma
2. Postinflammatory:
    Tubo-ovarian cyst; encysted peritonitis
3. Endometriosis:
    Chocolate cyst
4. Wolffian duct:
    Parovarian cyst; hydatid of Morgagni
5. Cystadenomata:
    Serous; pseudomucinous
    Papillary; nonpapillary
    Unilocular; multilocular
6. Benign connective tissue:
    Fibroma; leiomyoma
7. Teratoma; teratomatous dermoid
8. Special or dysontogenetic:
    - Biologically active:
        - Granulosa-theca-lutein cell tumor
        - Arrhenoblastoma
    - Biologically inactive:
        - Benign—Brenner tumor
        - Malignant—dysgerminoma
9. Primary malignant:
    - Cystadenocarcinoma
    - Solid adenocarcinoma
    - Epithelioma in dermoid (rare)
    - Carcinoma in endometriosis (rare)
    - Malignant dysontogenetic
        - Granulosa cell carcinoma
        - Dysgerminoma
    - Sarcoma
        - Primary fibrosarcoma
        - Sarcomatous teratoma
10. Metastatic malignant:
    - Müllerian adenocarcinoma
    - Intestinal adenocarcinoma
        - Krukenberg's tumor
    - Other metastatic malignant tumors

1. Physiologic. How can a structure be both pathologic and physiologic? When such a structure attains an arbitrarily fixed size for a similarly indicated period of time it must be considered potentially neoplastic, at least from the clinical point of view. There is no common agreement on this. From my own experience I set these limits at a structure the size of an average lemon, or 7 cm., or a little more than 2½ inches in its longest axis, which persists 2 months or longer.

After such an enlargement of the ovary is discovered the patient should be instructed to take an evening laxative followed by a morning soapsuds enema and then present herself for reëxamination. Not a few such pelvic masses prove to be moderate impactions of stool in the colon. Some women carry these habitually with no symptoms other than moderate chronic constipation.

The surgical treatment of persistent, enlarged follicles is resection of the follicle in order to preserve the ovary. There are two exceptions to this: first, when the ovary is badly distorted, as with extravasated blood, and there is a perfectly normal ovary on the opposite side; second, when there is a bilateral lutein cyst accompanying chorio-epithelioma which should be removed together with the primary growth.

2. Postinflammatory cysts. 3. Endometriosis.

4. Parovarian cysts. These are not primary ovarian lesions, although it is possible for a solitary nest of endometriosis to occur in the ovary. From a practical standpoint these must be included simply because many ovarian enlargements found on vaginal examination will ultimately prove to be one of the three. It is the frequency of occurrence of the first four classes that makes them important. Most diagnoses are made by a process of exclusion. These are the common lesions found at surgery. After they are excluded we then have left 6 primary types of ovarian neoplasms.

5. Cystadenomata. These include all well-encapsulated, cystic tumors of the ovary. They grow slowly, begin in one ovary, in time spread to the other, and may eventually become malignant. A solitary, unilocular cystoma may do nothing but grow larger if not removed. As a class, however, these must be regarded as potentially malignant. In younger women they may be treated by unilateral oöphorectomy provided careful follow-up is provided. In older women, or if there is breakthrough of the capsule or nodules infiltrating the meso-ovarium, bilateral salpingo-oöphorectomy and hysterectomy must be resorted to. This is one instance where the gross appearance of the tumor is more important than the microscopic one. Where there is breakthrough of the capsule or infiltration into the meso-ovarium or beyond, the tumor should then be classed as a primary carcinoma of the ovary and placed in class 9.

6. Benign connective tissue tumors. These are invariably fibromata or fibroleiomyomata. The Brenner tumor falls in this group also, but, since it is a rare dysontogenetic tumor, it is better classed in the latter group. The so-called Meigs syndrome, ascites and hydrothorax associated with a fibroma of the ovary, is rarely seen. This is probably because reports of such cases mention a very large tumor and one would rarely see an ovarian neoplasm grow so large before surgery is employed. Fibromas commonly show calcium deposits and areas of myxomatous degeneration.

7. Teratomas. These are greatly misunderstood. All dermoids are teratomas since they contain some connective tissue. The characteristic feature of the dermoid is its cystic nature and lining of skin-like squamous epithelium. If the tumor is largely solid and contains other tissues, it is a teratoma per se. Teratomas are rarely malignant but when so may be either squamous cell cancer arising in a dermoid or sarcoma developing in a teratoma. Conceivably any type of malignant tumor may arise in a teratoma. Hypernephroma and chorio-epithelioma, primary in the ovary, are considered malignant forms of teratoma.

Any type of tissue may be present in a teratoma. Cartilage, bone, brain, columnar epithelium and glandular acini are common. One type of tissue may predominate as, for example, thyroid gland, in which instance the condition is called struma ovarii by some. Struma as part of functioning hyperthyroidism has been reported. Jawbones and teeth are often seen in these tumors. Rudimentary limbs have been described attached to them.

8. Special dysontogenetic tumors. There are 4 of these. Two are biologically active; that is, they may produce sex hormones. The remaining 2 are biologically inactive; they never produce hormones. All 4 are peculiar to the gonad, 3 to the ovary alone.

Biologically active tumors are derived from the ovarian stromal cells. In the normally functioning ovary the stroma gives rise to theca cells surrounding follicles and granulosa cells lining them. Both may secrete estrogens in considerable quantity during the menstrual phases. After ovulation the granulosa and theca are quickly converted to the lutein cells of the corpus luteum, another potent source of hormones. It is not surprising then that the granulosa-theca-lutein cell tumors secrete estrogenic hormones and are called the feminizing tumors of the ovary. These cell types are derived from the ovarian stromal cells. These same stromal cells may undergo hyperplasia as an accompaniment of general endocrine dysfunction.

Arrhenoblastomas are masculinizing tumors of the ovary; they secrete male hormone and are of two histologic types. They are extremely rare. Most instances of hirsutism and virilism in women are not related to any endocrine neoplasm, ovarian or otherwise. I have seen many women of this nature. Two have had a pituitary tumor and one an adrenal cortical neoplasm. Although it has been my good fortune to study sections from several arrhenoblastomas, I have yet to see one develop in a patient under my observation.

One type of this tumor is well matured and exhibits structures similar to testicular tubules. This may actually be a form of true hermaphrodism. The other, while secreting male hormone, presents the appearance of the granulosa-theca-lutein cell tumor. I think of this form of arrhenoblastoma as that of vicarious hermaphrodism. It is derived from ovarian stroma cell elements but secretes testicular hormone.

Tumors labeled androblastoma, mesonephroma and other unusual names are not included in this classification. They have never found general acceptance, and there is a question as to whether they actually occur. Bizarre tumors of the ovary can usually be classed under the dysontogenetic group or as a form of teratoma.

Of the two biologically inactive tumors in this special group, one, the Brenner tumor, is always benign. The other, the dysgerminoma, is always malignant. Neither secretes any hormones.

The benign Brenner tumor appears and behaves grossly as a fibroma of the ovary. The diagnosis depends upon histologic demonstration of small, well-defined nests of clear, epithelium-like cells. These are the so-called Walthard's cell rests.

The dysgerminoma is always malignant. It is an embryonic form of carcinoma. This and the teratoma are the only tumors of the ovary that have analogous counterparts in the testicle. The embryonal carcinoma of the testicle is called the seminoma. This tumor histologically shows undifferentiated cells in a fine lymphoid stroma. It is highly malignant.

9. Primary malignant tumors. These have differential characteristics only in the early stages. Advanced disseminated disease is, unfortunately, the more frequent experience of the abdominal surgeon. When the tumor is localized to one ovary its gross appearance is most important. If there are roughened areas on the glistening capsule, gross break-through of the capsule, or nodular infiltration in the meso-ovarium or beyond, there is probable dissemination of the disease. This classification includes 4 sources of malignant epithelium in the ovary. A theoretic fifth one, the mesonephric rest, has never found general acceptance and is not included.

The germinal epithelium is a likely source of many cancers. It is a primary peritoneal structure and it is not surprising that tumors derived therefrom are found as disseminated disease at surgery. In the study of sections of normal ovaries I often see small nests of peritoneal and subperitoneal germinal inclusions. Occasionally there is a small, wart-like papilloma on the surface of the ovary, covered with germinal epithelium. I have also seen such a structure deep in the ovary in a cleft made by a Pflüger's tubule which could be followed directly to the peritoneal surface.

Granulosa cells, or any cells derived from ovarian stroma, can form granulosa cell carcinoma. I also consider the cystadenocarcinoma to originate from the granulosa of follicles. These tumors are always well contained in a strong capsule in their early stages, hence should originate within the ovary. The columnar epithelium of the pseudomucinous cystadenoma could originate in a teratoma, but other teratomatous elements are not found in these tumors. Several years ago it was my privilege to work with the late Dr. William S. Gardner of Baltimore, a distinguished gynecologist in his day. Although retired for some time, he still studied pathologic slides two mornings a week, a practice he had followed since he was a young physician in training in Vienna. One of his pet theories was the origin of columnar epithelium in ovarian follicles from the granulosa cell lining. Over a period of many years he collected more than 30 sections which showed not just a few cells, but an unmistakable and well-defined strip of continuous columnar epithelium which appeared to have developed from the granulosa cells lining the follicle.

At this point should be mentioned the condition of pseudomyxoma peritonaei. It is simply the disseminated stage of pseudomucinous cystadenocarcinoma so that when the surgeon opens the abdomen he finds it filled with mucinous material rather than the clear or straw-colored ascitic fluid ordinarily found.

Teratomas are the source of squamous and columnar epithelium. Squamous cell carcinoma arising in a dermoid cyst, while rare, appears to be a common form of malignancy in a dermoid. Theoretically, any form of tumor may arise in a teratoma. Blackwell and Dockerty[1] reported a carcinoid tumor, an argentaffin growth which is usually associated with the intestinal tract, arising in an ovarian teratoma.

Carcinoma may originate in endometrial cysts of the ovary. This, while also rare, is the fourth source of possible malignant epithelium. The embryonal carcinoma, or dysgerminoma, might be considered an additional source, but in this classification it is grouped with the malignant tumors originating from ovarian stromal cells.

Sarcoma may develop as fibrosarcoma primarily, or as sarcoma in a teratoma. The diagnosis may be difficult to make histologically. I recall one tumor which several pathologists agreed was a very cellular, but benign fibroma until the patient evidenced a pulmonary metastasis.

In connection with bizarre and unusual tumors we must bear in mind the theoretical possibility that any tumor may occur anywhere in the body. Neurofibrosarcoma of the ovary has been reported in a person with familial neurofibromatosis.

10. Metastatic malignant lesions. In the ovary these indicate widespread disease from some other source, the uterus and gastrointestinal tract being common ones. The seldom seen Krukenberg's tumor is a metastatic colloid adenocarcinoma from the gut. Similar tumors have been reported metastatic from the breast. Some names appear destined to be reproduced in textbooks forever with little reason therefor. Krukenberg described his tumor while a medical student and erred in calling it a sarcoma. He later became an eye specialist. At this point my mind queries facetiously, "Whatever became of Mittelschmerz?"

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RESULTS OF RADIOTHERAPY IN CERVICAL CANCER*

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DURING the years 1933 through 1952, a total of 812 patients with microspically proven cervical cancer applied for and received treatment in the Department of Radiotherapy at the Garfield Memorial Hospital in Washington, D.C.

The material has been periodically reviewed over the years and this is the final analysis. The patients are from both private and clinic sources, representing all social and economic levels. The patients were originally seen and referred by various clinics in the area, general practitioners, internists and other medical specialists. The entire material represents clinical cancer. All of the patients had either symptoms or signs consistent with the diagnosis. Thirty-seven per cent of the patients were of the Negro race, which is the approximate incidence of that race in Washington today. In other words, the material represents the disease as it probably exists in the community. There was no selection of cases over which the Department had any control. The policy of the Department prior to 1948 was to accept all cases, regardless of the extent of the disease, racial, social or economic status. During this time surgery was used very infrequently as a definitive form of treatment.

Table 1 summarizes the results of treatment in the entire group. It is noted that only 3 per cent of the total number of patients are untraced under 5 years, which represents an excellent follow-up and renders the statistics valid. In 26 cases the treatment was not definitive, and all of these patients are deceased. Treatment was not definitive because of several reasons: the patient refused to complete the course of treatment, became too ill, died before the contemplated treatments were given, or moved elsewhere.

TABLE 1

Results of Treatment in 812 Patients

(1933–1952 inclusive)

Minimum 5-year observation		672
Indeterminate group		44
A. Treatment not definitive	26	
B. Untraced under 5 years (3%)	18	
Determinate group		628
5-year survivals		225
Crude survival rate 672/225	33%	
Determinate group survival rate 628/225	35%	

Table 2 represents the 5-year survivals by stages. The League of Nations classification as revised in 1937 was used for classification with the exception that a separate group of "modified lesions" has been added. "Modified lesions" represents the cases in which a part of the treatment was given elsewhere and was unorthodox by our standards, or those cases of uncontrolled disease, either surgical or that were treated by radiation elsewhere. In staging, I have followed very carefully the following principles suggested

TABLE 2

Five-year Survivals by Stages

Determinate group 1933 through 1947

	CASES	SURVIVALS	PER CENT
Stage I	164	108	65
Stage II	264	93	35
Stage III	134	20	15
Stage IV	20	0	0
Modified	42	4	10

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* From the Radiological Clinic of Drs. Groover, Christie and Merritt, Garfield Memorial Hospital, Washington, D. C.

in the League of Nations Hand Book, viz., "In determining whether an individual case should be considered as an advanced example of a certain stage or an early example of a more advanced one, it should be made a general rule to allocate cases to the prognostically more favorable stages, in order not to raise unduly the rate for earlier stages." Using this criterion for classification, the incidence by stages in this material is as follows:

Stage I—28 per cent
Stage II—45 per cent
Stage III—22 per cent
Stage IV—4 per cent

In comparing results of treatment for various clinics over the world, one is impressed with two imponderable factors, as far as division into stages is concerned: (1) the concept of staging by different individuals, and (2) an undoubted variation in material in various clinics as to the extent of the disease.

When one considers that at least one half of the cases of stage II and all of the stage III, IV and the "modified lesions" represent advanced disease, and the added fact that there is a surprisingly high percentage of early primary lesions with nonclinical nodal involvement, it is indeed surprising that the results of radiation therapy in the material as seen in this Department are as good as they are.

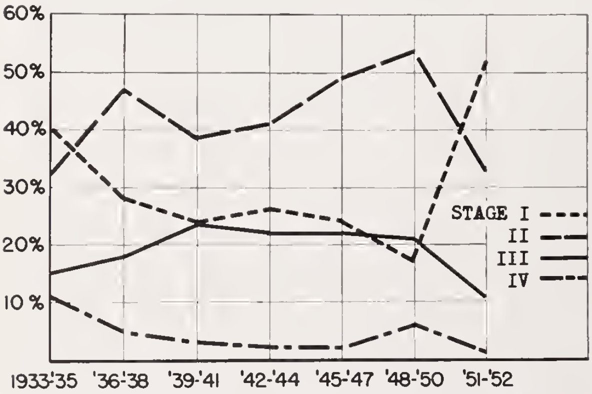

CHART 1. Variation in incidence of clinical stages.

Chart 1 demonstrates the incidence by stages over this period of time. It is difficult indeed, even from this chart, to determine whether cancer of the cervix is being seen at an earlier stage or not. The marked fluctuations in the incidence over the years is difficult to explain, particularly in view of the fact that the stages were determined by comparatively few individuals, all of whom were working together. The high incidence of stage I lesions in the years 1951 and 1952 suggests that there may be a trend toward a greater number of earlier cases.

Table 3 shows the results during the last 5 years, 1943–1947, in which 5-year statistics are available.

TABLE 3

Results during Last 5 Years in 293 Cases

(1943–1947 inclusive)

1. Indeterminate		21
A. Treatment not definitive	11	
B. Untraced under 5 years	10	
2. Determinate		272
Crude survival rate 293/99	34%	
Determinate group survival rate 272/99	36%	

Table 4 shows the results by stages during that same period of time. In the most recent group, it is noted that the over-all results are not improved with any degree of statistical significance. The survival rate in stage I has been increased appreciably, 72 per cent in the more recent figures as compared to 65 per cent for the entire group. A review of the incidence by stages would indicate that during the period of 1943 through 1947 the incidence of stage I (early lesions) was only 20 per cent as compared to a 28 per cent in the entire material, suggesting that more advanced disease was seen during this

TABLE 4

Five-year Survivals by Stages

Determinate group—1943 through 1947

	CASES	SURVIVALS	PER CENT
Stage I	58	42	72
Stage II	119	46	38
Stage III	66	9	13
Stage IV	9	0	0
Modified	20	2	10

(*Continued on page 244*)

PSYCHIATRIC CONCEPTS IN ESSENTIAL HYPERTENSION

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CLARIFICATION of the role of the emotions in essential hypertension has challenged modern medicine. Evidence pointing to a psychosomatic concept of the disease has been derived from clinical, psychiatric, and experimental investigation. Although the final answers still evade us, enough has been learned from these three disciplines to convince many competent observers that emotional disturbances play a significant role in the etiology and developmental course of the disorder. In this paper I shall attempt to summarize and evaluate some of the psychiatric data bearing on this subject.

For years astute clinicians have been aware of a high incidence of overt nervousness and maladjustment in hypertensive individuals. In the past two decades, a considerable number of psychoanalytically oriented studies have strengthened earlier clinical impressions regarding the frequency of important emotional difficulties in individuals with high blood pressure. Alexander,[1] Binger,[2] Flanders Dunbar,[3] and others have helped to document this thesis. Though these investigators often formulate their conclusions differently, and though there is some theoretic disagreement among them, their findings are actually quite similar. All believe that rather typical emotional problems are commonly present in hypertensives. In brief, these problems are thought to stem from lifelong conflicts between the individual's fears of his own repressed aggressive and hostile impulses and his more deeply repressed needs for dependent security. The actual or threatened thwarting of dependent strivings leads to further arousal of hostility which again needs to be repressed. The surface calm and self-control and the lack of self-assertiveness which hypertensives often display are thought to be outgrowths of this conflict.

Some nonanalytically oriented observers[4, 5] have stressed the elements of suppressed anger and subnormal assertiveness and have said little of underlying dependent needs. This may be because the former types of feelings are closer to the patient's own awareness. In my personal experience with hypertensives, both aspects of the emotional conflict have often been present. Analysts and nonanalysts agree that the elevation in blood pressure is probably connected, in some as yet unexplained manner, with the patient's unexpressed hostile feelings.

Investigations of this type have shed a good deal of light on the emotional difficulties of individual hypertensives. It remains to be proved, however, that the majority of persons affected with this disorder have an undue amount of emotional disturbance and that it generally centers around the areas mentioned. Many studies deal with too few cases. The patients investigated have usually been picked at random or been sent for psychiatric consultation because of obvious emotional difficulties. Only Dunbar[3] studied consecutive admissions to a large hospital. Control groups have not been used, and precautions have not been taken to guard against the bias and preconceptions of the investigator. The latter is especially important in a field where so much depends on subjective interpretation and where, with the best will in the world, it is easy to find what one is looking for.

Gressel and co-workers[4] have attempted to meet some of the above objections. They performed personality studies on 50 hypertensives and on 2 control groups, and they accepted their interpretations only after a number of observers had concurred in them. They concluded that there was a significant correlation between hypertension, obsessive-compulsive behavior, and subnormal assertiveness. Under statistical analysis, other personality factors, such as impulsiveness and anxiety, showed no such correlation with hypertension. They also made the interesting observation that the traits showing positive correlation were just as common in patients whose high blood pressure was on the basis of renal disease as in those in whom it was of the essential variety. Although this study corroborates only a small segment of the postulated personality problem, it does show that psychiatric patterns of a certain type are more frequent in hypertensives than in matched controls suffering from organic disease or psychoneurosis.

Weiss and his group,[6] in a still incomplete study, investigated 150 hypertensives admitted consecutively to the outpatient department of a large hospital. As a control they used 50 consecutively admitted asthmatics. On the basis of psychiatric interviews and psychologic testing, they concluded that a high proportion of their patients showed neurotic tendencies. However, they found that high blood pressure occurred in all types of personalities from the normal to the psychotic. Repressed hostility was a common finding, but it did not appear to be more frequent or of a different nature or degree in hypertensives than in patients with other psychosomatic afflictions. Though they state that no specific personality structure or emotional conflict was present in their hypertensives, they describe a frequently encountered psychologic pattern which corresponds closely to the psychoanalytic data previously mentioned in this paper.

Opponents of the psychosomatic approach often claim that hypertensives are nervous because they are sick rather than being sick because they are nervous. There is some truth in the former contention. It has been shown by Palmer,[7] for instance, that a discussion of the subject of high blood pressure with the patient caused a greater immediate increase in his pressure than other stressful subjects which were brought up. However, as already mentioned, psychiatric studies have demonstrated that these patients' emotional problems date back to early years. A review of the case histories of 100 patients followed at the Group Health Association Clinic both before and after the onset of high blood pressure bears out this point. The majority of these patients who were thought to be nervous after the condition had become established had already manifested such behavior before its onset.

In the study of psychosomatic diseases, attempts are often made to correlate the onset of the disorder with a period of preceding or concomitant emotional stress. Though some claims are made in the literature that this is frequently the case in hypertension, there is no reliable evidence to support this contention. Furthermore, such evidence will be hard to obtain, since most patients are neither under medical nor psychiatric observation during the onset of their disorder, which is apt to be insidious, difficult to date exactly, and devoid of symptoms. The patient's own idea as to when his blood pressure first became elevated is likely to be unreliable.

The evidence linking exacerbations and remissions in the disorder with variations in the patient's life situation is more convincing. Wolf and co-workers[5] demonstrated in 89 hypertensive patients that the blood pressure was higher during periods of stress and dissatisfaction and lower during times of security. Reiser and his group[8] demonstrated that in 12 cases the onset of the malignant stage of the disease occurred at a time when the patients were experiencing serious difficulties in their living. From a study of this small group of patients and of a much larger number of cases with a less severe form of the disease, Reiser concluded that the course of the disorder appeared to be affected when the patient encountered life situations evoking un-resolved major conflicts which could not be handled adequately through normal channels of expression and behavior.

Although corroboration of the chronologic association between stress and the course of the disease can often be made by the interested physician without undue probing, it is also true that many patients deny any relationship even when it is present. Some of these may volunteer such information at a later date when they have developed more confidence in their doctor. Others have used the psychologic mechanisms of denial and repression so successfully that they are unaware of the intensity, significance, and often even of the existence of their own feelings and reactions.

Although no long-term studies, controlled or otherwise, of the therapeutic value of psychiatric treatment in hypertension have been carried out, short-term observations have convinced most competent observers that psychotherapy fails to alter the natural course of the disease.[9] It is true, of course, that psychotherapy, whether applied unconsciously in the form of a medical régime or new drug, or administered consciously by the medical man or psychiatrist, will often lower the blood pressure itself for a variable period of time. Symptoms such as headache, dizziness, and palpitations are also likely to respond favorably. Results of this kind can generally be attributed to the psychotherapeutic benefits of a good doctor-patient relationship. Moreover, it has been shown that psychotherapeutic measures ranging from supportive therapy to intensive psychoanalysis can help many hypertensives to function more successfully and to live more satisfactory lives.[3, 6, 8]

Although various hypotheses might be offered to account for the fact that the disease process in hypertension is not altered by presently known methods of psychotherapy, we are still in no position to account for this phenomenon. However, it does not necessarily invalidate the many observations which appear to link emotional disturbances and high blood pressure. Such connections probably do exist, but they need further validation and elucidation. When the intricate pathophysiology of essential hypertension has been unraveled further, the already extant psychiatric data should fall into their proper place.

SUMMARY

Some of the psychiatric evidence bearing on the role of the emotions in essential hypertension is summarized and evaluated. It is shown that there is much to favor a psychosomatic concept of the disease, but that our present data need further validation. The exact role of the emotions in the disorder remains to be clarified.

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THYROID ABNORMALITIES FOUND ON CANCER DETECTION EXAMINATION

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VARIOUS studies have resulted in a considerable difference of opinion concerning the relationship between thyroid nodules and carcinoma. The work of Vanderlaan[1] and Rogers et al[2] indicates that malignant tumors of the thyroid gland are being overdiagnosed, and that according to autopsy statistics the disease is extremely rare and unimportant. These reports are considered inaccurate by others who point to the statistics of Cole et al,[3] Crile,[4] and others who encountered carcinoma in 7.5 per cent of all nodular goiters and 24 per cent of all single nodular goiters. These studies represent screened patients and are considered by some persons to be the statistics of alarmists. A review of the literature on these aspects of thyroid disease results in a great deal of confusion.

A different approach was suggested by inspection of the clinical material in the files of the Cancer Detection Clinic of Garfield Memorial Hospital. This is a "well patient" clinic, and those with complaints or symptoms of any disease are referred elsewhere. Because of this, it was felt that a study of this group would constitute an accurate picture of the incidence of thyroid disease in the "normal" adult population of a nongoitrous area.

From January 1, 1946 to December 31, 1952, a period of 7 years, 7,460 patients were examined. They ranged in age from 21 to 75 years. Females predominated. Following a complete examination the patients visiting the Cancer Detection Clinic are routinely referred back to their family physician with a report of any abnormalities discovered. After a reasonable time questionnaires are sent to the physician to determine the disposition of the patient.

The records of all patients seen during the 7-year period were reviewed, and 100 or 1.3 per cent were discovered to have a goiter. In this Clinic any enlargement of the thyroid gland beyond a physiologic variation is classified as a goiter.

The questionnaires showed that only 33 of the 100 patients having goiters were treated surgically for their disease. Of the remaining patients, 46 were advised by their physicians not to have surgery or, if they were so advised, rejected the advice. As far as can be determined 21 patients did not seek medical advice regarding the thyroid enlargement.

Table 1 tabulates the patients who underwent surgery with diagnoses made at the time of physical examination and the corresponding pathologic diagnoses. The lack of uniformity in both the clinical and pathologic diagnoses reflects the confused state of nomenclature of thyroid diseases. It is obvious that the clinical diagnoses were made by numerous examiners and that the excised tissues were examined by different pathologists.

Of the 33 patients who were operated upon, 2 were reported to have carcinoma on microscopic examination. It is interesting to note that neither of these cases was clinically diagnosed as carcinoma even in a clinic where the index of suspicion of cancer is great. This illustrates again the difficulty in detecting early thyroid carcinoma.

The 67 patients who did not submit to surgery represented the same clinical diagnoses in general as the 33 who were operated upon. Since 2

TABLE 1

Surgical Cases

	CLINICAL DIAGNOSIS	PATHOLOGIC DIAGNOSIS
1	Nodular thyroid	Colloid goiter
2	Cystic thyroid	Cyst on thyroid
3	Diffuse enlargement	Striated muscle
4	Nodular thyroid	Nodular thyroid, toxic
5	Multiple adenoma	Multiple adenoma with fetal adenoma
6	Multiple adenoma	Multiple adenoma
7	Adenoma	Fetal adenoma
8	Multiple adenoma	Multiple adenoma
9	Colloid adenoma	Colloid adenoma
10	Nodular thyroid	Nodular goiter
11	Adenoma	Nodular hyperplastic thyroiditis
12	Goiter	Substernal nodular goiter
13	Nodular thyroid	Nodular goiter
14	Adenoma	Adenoma
15	Multiple adenoma	Adenomatous thyroid with hyperplasia
16	Multiple adenoma	Papillary adenocarcinoma
17	Adenoma	Adenoma
18	Adenoma	Adenoma
19	Adenoma	Adenoma
20	Adenoma	Adenoma
21	Adenoma	Carcinoma
22	Colloid goiter	Colloid goiter
23	Symmetrical firm enlargement	Thyroiditis
24	Multiple nodular thyroid	Nodular and colloid goiter
25	Slight enlargement of isthmus	Nontoxic goiter
26	Diffuse enlargement, left lobe	Nodular nontoxic goiter
27	Adenoma	Nontoxic multinodular goiter
28	Adenoma	Adenoma
29	Multiple adenoma	Multiple colloid adenomas with cystic degeneration
30	Colloid goiter	Nodular goiter
31	Adenoma	Cystic adenoma
32	Adenoma	Hashimoto's struma
33	Adenoma	Adenoma

cases of carcinoma were found in the third of the series that came to surgery, it is possible that 4 additional cancers might have been discovered in the patients who were not operated upon. This would imply an incidence of malignancy in this group of roughly 6 per cent.

It is obvious that this series is too small to be of statistical significance, but this approach to the problem of thyroid disease, if applied in a large "well patient" clinic, would show the true prevalence of thyroid carcinoma.

SUMMARY

The incidence of goiters in the apparently healthy adult population seen at the Garfield Memorial Hospital Cancer Detection Clinic is approximately 1.3 per cent. Of this group definitely 2 per cent were malignant, and probably as much as 6 per cent could have been malignant if all the patients had been operated upon.

The interest of the apparently healthy patient in the presence of asymptomatic thyroid enlargements is not as great as might have been anticipated from the volume of cancer publicity circulated.

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THE OBSESSIVE PERSONALITY*

The Clinical and Dynamic Features of the Obsessive Character Defenses

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WITH the consideration of the obsessive-compulsive defenses we are about to begin the study of another major pattern of psychologic defense. This discussion is concerned primarily with that pattern of personality which is marked by the presence of obsessive character traits. Separate study of this group of character traits or defenses is clearly indicated in view of their ubiquitous incidence, their importance medically, socially and individually, and, in view of the clear-cut personality pattern, distinguishable. As we shall learn, this type of defense against anxiety can result in the development of the important obsessive constellation of personality traits, as well as a major category of psychoneurosis. The latter, obsessive-compulsive neurosis together with the impulsions, will be considered separately, next in sequence.

Obsessive traits include meticulousness, orderliness, overconscientiousness, rigidity, persistence, parsimoniousness, procrastination, obstinance, and indecision. While a complete list will follow later, it is evident how widespread is the possession of these traits. As a group, they may serve a somewhat equivalent purpose to neurotic obsessive symptoms; may, when effective, prevent their development, and may, when they are ineffective or tend to crumble under added stress, appear to be prodromal to a later neurosis. The obsessive character defenses have increasingly come to be recognized as a related group of traits making up what we may call the obsessive personality.

This introduction will serve to acquaint us with the obsessive-compulsive defenses somewhat generally including the neurosis and will include brief historical notes. I shall present appropriate descriptive data concerning certain aspects of the obsessive personality. Together with several illustrative case summaries this may help us gain some appreciation of the profound social, medical, personal and professional implications of this very important group of character defenses. A tabulation of the traits to be properly considered as obsessive will be made. Certain psychodynamic considerations will be included with more to follow when we study this type of neurosis. Finally, a comparative tabulation will be made with the hysterical and depressive groups of character defenses described earlier. A consideration of certain salient factors in treatment will be deferred following the subsequent presentation of obsessive-compulsive neurosis.

Interest in the observation and study of obsessional cases has paralleled the modern history of psychiatry. In the beginning attempts at the classification and differentiation of the various psychiatric conditions, this group was rather early isolated. Esquirol in 1838 originally described *la folie de doubte*. Later, in 1861, Morel, another French psychiatrist, first used the name obsession. In 1878 Westphal[1] defined obsessions as ideas which appear "contrary to the patients' volition, cannot be banished, . . . and (which) are recognized by those affected as abnormal. . . ." While current definitions, as we shall shortly see, may offer some advantages, Westphal's early one remains essentially correct. An understanding of obsessional psychopathology and the dynamics involved likewise began early. Sigmund Freud[2] pointed out that psychoanalysis was built primarily upon the study of hysteria and obsessional neurosis.

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* Read before the Section on Neurology and Psychiatry of The Medical Society of the District of Columbia, March 4, 1954. This is the seventh article by Dr. Laughlin in this series on the psychoneuroses. The next, entitled "The Obsessive-Compulsive Neuroses," will appear in the May issue of the Medical Annals.

As has been observed about considerable other areas of knowledge in regard to human behavior, we might anticipate actual or intuitive recognition of the obsessive-compulsive processes by observant philosophers and savants of earlier eras. We might also rather expect to observe the assignment of obsessive or compulsive traits by an author to a fictional character. An instance of the latter, antedating modern scientific recognition and study, is to be found in one of the better known works of Samuel Taylor Coleridge (1772–1834). In "The Rime of the Ancient Mariner"[3] (1798) the reader may recall that the ancient storyteller is pictured as under a compulsion to tell his arresting tale:

> "Since then at an uncertain hour,
> That agony returns;
> And till my ghostly tale is told,
> This heart within me burns . . . "

Herein Coleridge conveys one essential feature of the compulsion, i.e., the discomfort that is present until the compulsion is obeyed. As William A. White[4] described in the more severe instances of compulsive neurosis, "If these compulsions are resisted or interfered with, they give rise to certain symptoms which in marked cases constitute a veritable crisis. The patient feels weak, trembles, becomes dizzy, perspires and finally yields, to find that at once all these symptoms disappear."

In the obsessive-compulsive neuroses, anxiety is held in check by the intrusion into consciousness of insistent, repetitive ideas or by similar urges to action. These intrusions are generally unwelcome or repugnant to the patient. They are usually regarded by him as senseless, unreasonable or silly. As a result, the patient consciously struggles against them. Actually, it is often the resulting discomfort of his relative helplessness and powerlessness to suppress his obsessive thoughts and compulsive urges that leads the patient to seek professional help.

We may define obsessions and compulsions as follows:[5]

OBSESSION—an insistent, repetitive, intrusive, and unwanted thought.

COMPULSION—an insistent, repetitive, intrusive, and unwanted urge to act.

Obsessive thoughts may include doubts, wishes, fears, impulses, prohibitions, warnings, admonitions, and commands. We can see the close relation between obsessions and compulsions, both of which are usually highly subjective manifestations. A compulsion is an internal command, a command from within oneself. Although clear reasons exist for the presence and content in every instance of obsessive thought, character trait, or compulsion, these are not consciously accessible to the patient, nor can the trained and experienced observer firmly establish the reasons without considerable study in each individual case.

Compulsions and obsessions were earlier included under "psychasthenia," a term introduced in 1903 by the French clinician, Janet. Janet also deserves credit for excellent descriptive observations in this field. Psychasthenia originally also included the phobias and certain other emotional illnesses. Literally meaning "psychic weakness," this term gives us an indication of some of the early ideas about etiology. As a diagnostic label, psychasthenia is heard more and more rarely. Recently the phobias have been officially (A.M.A. and A.P.A.) separated for purposes of classification.[6] They are, however, related to obsessions and compulsions and will be considered separately in the next article of this series.

Authorities in general agree that the obsessive-compulsive reactions are typically found among those who are more favored intellectually.

Representative of this is Freud's comment[7] about these people being "... as a rule intellectually gifted above the average." Modern society places a premium on the possession of certain obsessive traits. Thus, a certain amount of orderliness, neatness, punctuality, precision, meticulousness, and cleanliness is highly useful personally and is culturally desirable. This is illustrated by the wide quotation of admonitions such as Samuel Smile's "A place for everything and everything in its place." On the other hand, however, an obsessive-compulsive neurosis in its most advanced form may be one of the most excruciating and tormenting of illnesses. There is a gradation between the so-called "normal" and the pathological that is so gradual, however, that a clear line may be indeed difficult to draw.

Character analysis* of the person with obsessive character defenses can be highly useful. With these patients their traits of persistence, application and conscientiousness are very useful when applied to the hard work and necessary collaboration of investigative psychotherapy. Likewise, substantial benefits may accrue from therapy with many cases of actual obsessive-compulsive neurosis. The prognosis is to be increasingly guarded when the case is more firmly established, of longer duration, and of greater severity.

A great body of knowledge has been accumulated during the past 60 years which places the experienced psychiatrist in a relatively advantageous position to assist this entire group of patients. This favorable position of the therapist in treatment, together with our recognition of the caliber of person affected, and his high actual or potential level of social usefulness, increases our medical responsibility. Making an accurate diagnosis and securing adequate treatment in suitable cases can be a worthwhile and highly rewarding endeavor.

THE OBSESSIVE CHARACTER DEFENSES: THE OBSESSIVE PERSONALITY

There are a group of personality traits or character defenses which we have come to recognize as frequently grouped together in a constellation which constitutes the obsessive personality. Freud[8] in 1913, discussing "the predisposition to obsessional neurosis," early noted a distinction between the neurosis proper and the compulsive neurotic character. In the neurosis there is a failure of repression with the emergence or threatened emergence to consciousness of the repressed material. In the formation of character traits repression is successful and there are reaction formations and sublimations. Typically seen are several of the following characteristics: meticulousness, perfectionism, overconscientiousness, parsimoniousness, overconcern with detail, doubt or indecision, and inhibition. These and similar traits are developed gradually as part of the basic character defenses against anxiety. They serve as a means of promoting security by reënforcing the containment of threatening and rejected aggressive and/or sexual impulses.

The obsessive group constitutes the third major group of character defenses which we have outlined. In the November ANNALS you will recall the discussion of the hysterical character traits which served, in less obvious form, purposes similar to those achieved in more apparent and pathologic fashion by the major symptoms of conversion hysteria.[9] In the December ANNALS I outlined certain character traits which appear to develop in similar relationship to depression and which were divided into two major groups.[10]

As noted earlier, the development and maintenance of complex social and economic cultures place a certain premium on a number of the obsessive personality traits when they are present in moderate degree. This is true in our present system as witness the literary position and achievements of men like Ben Jonson and Noah Webster. This was likely also true in those more highly developed civilizations of past eras.

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* Character analysis is the term often used in psychoanalytic treatment where the aim is primarily the analysis of personality and character traits as opposed to more specifically neurotic symptoms.

In view of their social acceptability and usefulness, it is not surprising to find these traits in varying degrees of prominence quite widespread. Thus, the presence of obsessive character defenses is much more widespread, and as a result of their study could be considered of greater moment than the cases in which actual neurotic symptoms have developed.

Different character traits may be present in varying degrees and in varying combinations.

This makes it impossible to indicate clear boundary lines or to establish absolute criteria. Important and noteworthy personality characteristics do not develop by chance. They come into existence as the result of powerful internal psychologic needs, attempting to serve vital defensive purposes. The obsessive personality traits may attempt to serve a similar purpose to those which have been repeatedly demonstrated as underlying actual obsessive neurotic symptoms. Herein they may aid in the maintenance of repression and control of denied and rejected hostility and aggression or of disowned sexual impulses. Certain of them (i.e., overcontrol and inhibition, shyness, self-effacement, oversolicitude or considerateness, overmoralism, scrupulousness or cleanliness) have a clearer origin in reaction formation against the repressed and denied drives.

Other traits in this group include orderliness, neatness, rigid punctuality and truthfulness, obstinacy, love of symmetry, industriousness, and conventionality. These may to some extent be reflected in dress and manner which can in extent approach the ritualistic. Rules, regulations and small social conventions may be followed rigorously. Mixed feelings (termed ambivalence) are often marked both in regard to a particular person and to goals and conflicting desires. This helps us understand the great amount of doubt and indecision which is rather characteristic of the obsessive personality. The ambivalence also helps account for the procrastination which is a frequent handicapping trait. It is very difficult to make decisions when feelings are divided, even more so when one is unwilling to make some sacrifice either way. In this respect the obsessive often "wants to have his cake and eat it too!" Only too often, there are apt to be lingering doubts or regrets and "rehashing" of the situation following a decision. At times one sees overattention to the threat or possible prospect of death.

The obsessive person is often an excellent curator, hobbyist, or collector. His ability to handle money is often superior, and he may save or "collect" this also, a trait which may approach hoarding and miserliness in extent. Attitudes toward money may sometimes appear paradoxical. Small expenditures may be made grudgingly to the point of self-deprivation and miserliness, whereas large sums may be dispersed with relatively little concern. This type of collecting can also enter into the obsessive accumulation of knowledge, a not infrequently seen scholarly pursuit in many fields of academic and professional endeavor. (Ferenczi[11] among others has discussed the possible relations of bowel habit training and feces in infancy to later adult interest in money, relationships not as necessarily absolute and definite as thought earlier.)

Outwardly the obsessive person may appear quite self-possessed, independent, and even aloof. This is only too often an outward facade for inner self-doubt and hidden desires for dependence. For example, the person who fears he knows little or is poorly informed may have a greater need to try and present the outward appearance of knowing a great deal. A variation of this is not infrequently seen in the adolescent who wants to appear and to be treated as an adult. This kind of need may persist into or even be exaggerated in adulthood. In these instances the inner doubts may result in a need to be important (actually an hypertrophied desire to be grown-up and accepted as such). The hidden self-doubts may lead to an outer formal facade as an attempted defense. Thus the obsessive personality may have trouble being informal and may overdo in his expectations of respect and deference from others. He may resent informality toward himself for several reasons, including the above, and as a defensive "distance-promoting" mechanism. He may himself be formal to the point of being pompous, pedantic, and a "stuffed-shirt."

As noted, these people are often highly able, respected, contributing citizens. As Bleuler[12] said, ". . . they are diligent and conscientious people. . . . The intelligence is strikingly often above the normal." Accordingly, it is not surprising for us to find, upon testing, I. Q.'s in the superior range, 120–130 or higher.

In turn the obsessive personality may take pride in his intellectual status and achievements. His pride in accomplishments may be exaggerated as a reflection of his hidden self-doubts. One may see an occasional somewhat related obsessive interest in words. Overimportance and sometimes pride may be attached to their choice and usage and to the accumulation of a vocabulary. Similar interest may be shown in numbers or in geometric designs. One outward indication of obsessive trends is sometimes evident in an individual's doodling.

I recall that Freud once made a reference, the location of which I cannot at this point place, to the superior intelligence of the obsessive possibly having some developmental relationship in psychologic factors, similar to that of other more clearly recognized character defenses. This is an interesting point for speculation. The development of traits such as industriousness, pertinacity, and application at the least insure good use of existing capacities. Further, memory, as an important facet of intellectual ability, is usually superior. Patterns of thoroughness, exactness, order, and precise arrangement as developed are frequently operative in the field of memory as in other aspects of function. This would certainly tend to increase the intellectual efficiency and effectiveness of the obsessional personality.

These people often struggle against their feelings, which are, however, intense. They may make special efforts to justify feelings to themselves or to others; feelings, particularly angry ones, being more acceptable if they can be justified so as to seem appropriate, to fit the circumstances. They may be expert at rationalization in response to trying to satisfy the demands of a harsh superego. Incongruities between standards and behavior can exist and are to some extent "reconciled" in this manner. There may be a history of minor stealing such as shoplifting in childhood or adolescence as a self-sought way of making up for felt deprivations (really love and affection but often expressed in terms of material things). The conscience overdevelops partly as a way of controlling these and other powerful, disturbing and disapproved impulses. A persistence of this type of dishonesty into adult life is occasionally seen in which it remains permissible to take things of little real monetary value but not things which have a more clearly demonstrable worth.

At times overcompliance and obedience are seen in at least outwardly exaggerated form. In perhaps seeming contrast to the indecision described, the obsessive person may be rigid, moralistic, and absolute in his judgments. In this respect he may be a "black or white" person. Something or some one is either good or bad, clean or dirty, right or wrong, social or antisocial, ethical or not. There may be little tolerance or margin given in such judgments, no room in between. In this respect the harsh judgments apply equally to others as to themselves or aspects of themselves. Other people are expected to measure up to the same high standards which have been set personally. They may seem opinionated, overly correct, and sanctimonious, and possess high ethical standards.

The obsessive personality has an especially strong tendency to expect others to think and feel as he does. He may have little appreciation that wide variations in attitudes exist among people, in his needs to judge others by himself. Thus, he may be genuinely surprised at selflessness, genuine emotions, warmth and empathy in others, since these may be greatly restricted in himself. On a deeper level, his self-condemnation and doubt may be a reflection of a recognition of such discrepancies within himself (as well as a reflection of demanding and critical parental attitudes, etc., the incorporated judgmental parent). He may compare himself unfavorably with others, sometimes in many areas in addition to, or even avoiding the realistic ones. This may be a reflection also of his hidden strong underlying self-doubt and feelings of inferiority. The latter may in turn be concealed by an outward appearance of superiority, sometimes to an offensive extent.

The obsessive is frequently prone to use the defense of the pessimistic outlook. One anticipates the worst and then whatever happens will be less evil than is expected, with resulting relief. Unpleasant surprise is guarded against. However, since the pain of anticipation is so strong, the amount of suffering is always mathematically greater. The patient may himself recognize this in part or in whole and still be totally unable to surrender or modify his defense of pessimism. The defense of pessimism may not make as much sense to the objective observer as to the person who employs it. At times it is, of course, self-defeating and may even seem ludicrous. Thomas Hardy's "Epitaph on a Pessimist" has a wry kind of humor:

"I'm Smith of Stoke and sixty-odd,
I've lived without a dame
From youth-time on; and would to God
My dad had done the same."

McL. Wilson poetically differentiates the two extremes of outlook in his "Optimist and Pessimist":

"Twixt optimist and pessimist
The difference is droll.
The optimist sees the doughnut,
The pessimist the hole."

Obsessive character traits may adequately serve their defensively intended purpose so that the status quo of personality adjustment is maintained. The result is a harmoniously balanced person with perhaps just enough obsessive trends to facilitate constructive living. On the other hand, the unfavorable effect of stressful internal and/or external factors may result in these character defenses being no longer adequate with their overdevelopment and exaggeration to the point of interference with living; happiness, interpersonal relationships, achievements, or satisfactions; or the onset of actual obsessive neurotic symptoms.

The following case illustrates the obsessive personality in which the development of defensive character traits had surpassed the defensively intended purposes. In their overdevelopment they became limiting and handicapping and efficiency was lost.

Case 1. A 38-year-old business executive was referred for psychiatric evaluation and possible treatment by his physician because of his overconcern with health, increasing dissatisfaction with his work, and some indications of family friction.

Upon consultation, the patient was pleasant in manner and carefully dressed. He seemed, however, rather precise and slightly pompous in manner. He gave an impression of considerable energy, ability, and intelligence. As the interview progressed there were suggestions of high personal standards of performance, rigidity, and concern with detail which together had adversely affected his potential level of efficiency as well as his self-esteem. These factors had undoubtedly also influenced relationships at home and at work, contributing to his dissatisfaction, and limiting energy otherwise available for more constructive activity. Character analysis was advised.

During the course of therapy these and related well-established character defenses were found to have thoroughly influenced the entire course of his life. The application of his own harsh standards to his family and associates had greatly increased the difficulty of others being able to please or satisfy him. His need for meticulousness had restricted his breadth of vision and occupied his attention with unnecessary detail. Despite his outward appearance of self-possession, he was afflicted with tortuous self-doubts and indecision. Characteristically, there was intense ambivalence, with evidence of urgent repressive efforts to continue the containment of the strong negative aspects, which were most unacceptable and threatening to him.

As the details of his emotional and developmental history unfolded, there was evidence of ambivalent parental attitudes toward him in turn. During his infantile years his parents were tolerant and permissive and encouraged him to be dependent. This situation was reversed rather abruptly in subsequent years, with stringent demands for conformity and independence. Such a contrast resulted in more hostility than might otherwise have been present, with a simultaneous increased need for its control and repression. The character traits developed as additional defenses to aid in this vital endeavor. To a point they served a useful purpose in a complex social and economic order. However, these same traits when overdeveloped became professionally limiting and personally handicapping. This feature of being useful and constructive up to a certain point, but destructive and self-defeating when developed beyond that point, is often illustrated and is rather typical of obsessive character traits.

He applied himself with energy and conscientious endeavor in the intensive study of himself. The results of treatment were good. He became slowly able to recognize more and more of the tremendous hostility which had been seething in hidden and repressed form within himself. As he found himself able to handle this on more conscious levels, it became less of a threat. He was able to gradually adopt a kinder, more tolerant attitude toward himself, and as a result became more accepting of his associates. His family relationships improved greatly. The necessary large investment of his time, energy and money in a character analysis was very worthwhile for this man. In his case, however, as with most instances of obsessive characters, treatment was prolonged and difficult. This latter observation is amply supported by Fenichel[13] and others.

As illustrated in the above case, the maintenance of high personal standards of achievement and highly self-critical attitudes are evidence of the overdeveloped conscience or superego. The latter had in essence hypertrophied in response to the need for control of powerful aggressive impulses which had in turn been stimulated by the relative change in attitude of parents from overprotective to demanding.

At this point it might be helpful to tabulate the traits (table 1) which are most commonly considered as helping to make up the obsessive personality. A number of these are usually seen together in various combinations and varying relative strength. A certain number are also required to make up a constellation of traits sufficiently characteristic to warrant the use of Obsessive Personality as a diagnostic classification.

TABLE 1

The Obsessive Character Defenses

A summary of those character traits more commonly to be considered as belonging in the Obsessive-Compulsive Group. When a number are present together, and to a recognizable degree, they collectively make up the Obsessive Personality.

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1. Superior intelligence
2. Meticulousness
3. Overconscientiousness
4. Idealism
5. Overconcern with detail
6. Stubbornness
7. Industriousness
8. Preciseness
9. Overcleanliness
10. Ambivalence
11. Overseriousness
12. Intolerance
13. Orderliness
14. Doubt
15. Rigidity
16. Overly moralistic
17. Overcontrol
18. Diligence
19. Collecting
20. Tidiness
21. Inhibition
22. Pertinacity
23. Love of symmetry
24. Pessimism
25. Indecision (lingering doubts not uncommonly follow whatever decision is made)
26. Procrastination
27. Self-effacement
28. Restricted freedom of thinking and imagination, and sense of humor
29. Overscrupulousness
30. Parsimoniousness
31. Harsh self-judgments
32. Strong sense of duty
33. Overconcern with truth
34. Minute following of rules, regulations, and small social conventions
35. Harsh judgments, high standards, "black or white" outlook
36. Feelings of inadequacy and self-doubt may be strongly present, which are often also unrealistic, and opposite traits may be exhibited outwardly as a defensive "reaction of the opposite"

As indicated, these character defense traits have developed as part of the early desperate struggle to keep censored feelings from recognition (repressed) and continue in order to maintain repression. With the absorption of energy in resulting activities, there is less available for libidinal attachments and for sexual outlets. Also, sexual feelings may themselves be part of the censored material which has contributed to the psychologic necessity for the development of obsessive traits. Sexual expression and sexual drives may also be under more rigid control as a result of the general inhibition or of the restriction of the affectivity generally which is rather common to these patients. As a result, it is not surprising to find a history of decreased sexual activity or apparent interests. This in turn, however, does not frequently serve as a matter of complaint by the patient.

Intimate personal relationships are likewise often restricted, a feature which is then reflected in marital relationships and in love-making. A number of handicaps may appear in the latter. These may include such things as a distaste for caressing, for sexual foreplay or for kissing; which may be explained (or rationalized) on the basis of esthetic or moral grounds, or upon standards of personal cleanliness. There may be difficulty in marriage in adjusting sexual relations to mutual satisfaction with a lack of, or decreased ability to secure mutual simultaneous orgasm. Moral scruples often interfere with sexual activity. The obsessive personality may suffer from undue guilt or shame or be terribly concerned and overly fearful of the possible consequences of his sexual drives. Conflicts may be severe should there have been premarital sexual experiences. The sexual drive is usually strong in some contrast to other types of emotional difficulty, but with the drives overinhibited by various elements of an overdeveloped superego. An unfavorable and disapproving attitude toward sex, when present, may vary all the way from one of "it's not nice" to one of loathing and disgust or revulsion.

Let us consider briefly how character traits and patterns of behavior can attempt to serve a psychologically defensive purpose. A simplified example may be taken of the trait of indirectness or vagueness. A patient in intensive psychotherapy recently worked out with me how he used one aspect of this (the raising of questions by implication only, in place of asking them directly) as a defense against his anxiety. In the event of asking a direct question, the failure to secure the response which he desired made him angry, while the failure to secure any answer at all made him feel furious and rebuffed. In addition, either circumstance served as more pointed evidence to himself of his inability to control the other person and as a more pointed illustration of his relative helplessness. On a deeper level this helplessness carried back to his more primitive infantile feelings of helplessness in relation to his (then) all-powerful parents. Infantile anxiety in response to this which had never been adequately worked through was in a sense reactivated. Anxiety in turn, as often occurs, found a rather ready outlet by the subjective transition into anger. When an answer was requested by implication only, the direct request and the danger noted were avoided. In addition, he could make many explanations to himself if it failed to be forthcoming. Vagueness can, of course, have other implications, e.g., the stimulation of the other person to stronger, even utmost endeavors to understand, to anticipate, or to please. Also, vagueness, like tentativeness and lack of commitment, tends to place one in a stronger position of defensiveness and control.

Obsessiveness can enter into many activities. Reading is not an uncommon example as to quantity or manner. One patient recently described her obsessive reading habits which had developed to the point where only a few pages could be covered in an hour. Paragraphs or sentences had to be read and reread repeatedly to "make sure of the meaning" or to "be sure not to miss something."

In the following example, a patient worked out the reasons for his obsessively cautious driving.

Case 2. A 40-year-old business man was in treatment essentially because certain obsessive traits interfered with his interpersonal relationships and had hampered his career. During the course of treatment a pattern of painfully overprudent driving had become apparent. Despite his extreme overcaution and painstakingly minute following of traffic rules, sufficient at times to drive his friends to distraction, he still somehow managed to become involved in several minor "accidents" each year. His associations gradually indicated that he was by these cautious driving habits unwittingly attempting to protect against his own strong rejected aggressive impulses. These in turn had appeared to play a part in psychologically determining at least 2 of the accidents investigated. The result was an outward but hidden expression of his inner disowned hostility which, not clearly understood, was all the more frightening and led to increasing attempts at control through caution. This tended to create a vicious circle. Since he also suffered in the overcautious efforts at control, there was a certain simultaneous retribution or self-punishment exacted.

This case helps illustrate the close relationship between obsessions and phobias. I have described this instance as illustrating obsessive caution which it is. Yet the line of distinction here from a phobia about accidents, i.e., by definition[5] "a morbid fear (of accidents), out of proportion to the apparent stimulus," is not overly distinct. This close relationship is apparent in other emotional symptomatology. For instance, a phobia about dirt or germs may be closely related to obsessive cleanliness. Our understanding of the kindred association of obsessions and phobias will later help our study of the psychoneuroses and make an easy transition from the one to the other. It also helps explain why Janet included phobias with obsessions and compulsions under the term psychasthenia, an association which was continued by various authorities despite gradual discard of the term until quite recently (1952), when revision of nomenclature and classification finally separated them.

It is important to the physician, who frequently prescribes dietary restrictions and then often has to struggle with their observation, to recognize the very important adversary to good health implicit in compulsive eating. This problem was briefly mentioned earlier in discussing the relation of anxiety to overeating.[14] An internist recently reported to me his despair over a cardiac patient whose persistent moderate overweight threatened to contribute to his early demise. Explanations, urging, pleading, and even threats seemed to no avail. Despite the best efforts of patient and doctor, gains seemed small and were soon enough more than replaced. The physician felt helpless, as indeed he was. This patient's eating followed a compulsive pattern in response to powerful internal psychologic needs.

Compulsive overeating is by no means infrequent. It can defeat the most carefully designed dietary régime and bring the sincere and conscientious physician to despair. Unfortunately, there are no easy solutions in these situations. Sometimes patients have no interest in the constructive self-study of psychotherapy, or they may have to justify their fears and apprehensions of possible psychiatric treatment by various explanations and rationalizations. Fortunately, in occasional instances the patient can be interested in a psychotherapeutic approach where the existing somatic pathologic process actually present is not so far advanced as to be a contraindication by virtue of a dangerous possible exacerbation during treatment.

An additional example will be helpful in our consideration of this largest group of character defenses. In the following case the more marked traits were obstinacy, parsimony, perfectionism, and a certain personality rigidity with a resistance to any kind of change.

Case 3. The patient, a 36-year-old production manager of a small manufacturing plant, had been under intermittent medical treatment for a year for chronic constipation. The physician observantly noted the presence of certain rather characteristic personality traits during their professional association as he learned to know him better. Consultation was recommended with the hope that a character analysis might prove feasible.

When first seen, the patient discussed the problems in his relationship with the company president. Part of the difficulty appeared to be a conflict between the latter's interest in quantity of production and the patient's needs for perfection of detail and precision.

I was further impressed with qualities of superior intelligence, the maintenance of high personal standards, careful, well-chosen dress, precise habits, and evidence of a certain rigidity of manner and thinking. During a trial period of treatment it became clear that the rigidity included a certain resistance to the acceptance of new ideas or to change and a certain obstinance to following suggestions from others. This applied in all phases of living, at home and socially, as well as at work. He was uncomfortable if prevented from religiously following his daily practice of taking two thorough shower baths with several complete changes of clothing. His family relationships were rather distant, and during the early work of treatment relatively little was learned about either his immediate family or early family interrelations. There was a distinct and handicapping tendency toward parsimoniousness. This extended into business operations in which the fact that the latter did not involve his own funds made no appreciable difference.

It is evident that certain of his traits could be an asset (for example, thoroughness, conscientiousness, intelligence, application, serious endeavor and precision) to the sometimes difficult work of character analysis, while others (rigidity, obstinancy, overcaution, restricted freedom of thinking, and need to control by withholding) necessarily complicated and prolonged the work. Most of these traits are sometimes referred to by psychiatrists as "anal character traits," thus denoting (1) their earlier presumed definite origin in this stage of infantile training and development, and (2) their not infrequent relation to habits and patterns of bowel function. Our awareness of this helped point up the relation between this patient's problem with constipation and his character traits—more of which we shall see later in our study of dynamics. The referring physician had been happily aware of the possibility of such relationships and was alert to the possible presence of the traits which upon observation proved to be actually present. Incidentally, the title of his job, "production manager," and the difficulties he experienced in it, are of interest in view of their possible anal implications.

Prior to his promotion to this position his interest in detail, his rigidity and need for precision, etc. had contributed substantially to the development of excellent, carefully engineered new products. The firm had prospered and his promotion followed. However, in his new role, where his job was to expedite production and increase quantity, these same traits understandably handicapped himself and hampered the business.

As might be expected, this patient was highly self-critical. This proved to be partly a direct reflection of his harsh, overdeveloped conscience (superego) and partly an inversion of hidden disowned aggressive and punitive attitudes toward others. The latter process is similar to the inversion of hostility, which has been earlier illustrated in the study of depression.[9] The obstinacy, which at times amounted to perversity, was an immature and vestigial carry-over of an infantile power mechanism, in which the control exercised in this withholding manner helps combat the anxiety-provoking feelings of helplessness. His need for cleanliness proved to have symbolic meanings related to feelings of moral cleanliness; the purity of his body by bathing had to some extent come to equate the moral purity of soul.

This is a necessarily fragmentary summary of only a very few facets of the complex genesis of several of his outstanding character traits. Unfortunately, the details of how the patient and I collaborated intensively for over three years to work out many of the hidden aspects of his personality development cannot be presented here. This patient was able, however, to successfully make some substantial readjustments as his defensive needs for precision, rigidity, and overcaution lessened. His work and professional relationships have improved markedly. Production rate per employee has increased, and the plant has expanded, some of which has been undoubtedly a reflection of his diminishing overdeveloped needs for rigidity and precision. Family relationships are closer, fuller, and more satisfying.

As in the above case, a thorough and successful study and analysis of character traits invariably is followed by certain modifications. As the needs for their defensive purposes come more into awareness the needs themselves diminish. Since the underlying psychologic needs were powerful and tenacious, character defenses had been formed which were clung to desperately. These are not surrendered readily in whole or in part without great struggle. This is true despite the fact that character traits in their overdevelopment are often psychologically uneconomic, and to an objective observer are actually often seriously handicapping and defeating to the person concerned. Since their development is in response to strong psychologic defensive needs which are mainly out of conscious awareness, it is indeed not surprising that in the very instances where they are most exaggerated and most personally defeating, they are held on to most tenaciously and desperately.

The defensive mechanism of character trait-formation is quite analogous to the more clearly pathologic development of definite neurotic symptoms in which the self-defeating and psychologically uneconomic outward aspects are often much more striking. This analogy, however, gives us a better basis for the understanding of character defenses which many physicians are less accustomed to think of as psychologic phenomena but which are of a high level of importance to the individuals' potential social and professional development as well as to his personal well-being. In effect, one can compare the great self-limitation and sacrifice which we saw imposed upon a given individual by the gross conversion symptom and less dramatically by certain other psychopathologic manifestations to the concomitant sequelae of hypertrophied character defenses. Various investigators have commented on the need of the obsessive to prove his omnipotence. Deutsch,[15] as have others, points out the superstition seen in obsessionals which is inconsistent with the high intelligence. This has not been as prominent in my own experience as reported by others.

The analysis of character defenses where they have served, often unwittingly, to handicap an individual is an area of great potential usefulness to many people and one which is likely to undergo considerable further development and application.

I have outlined thus far three distinct groups of character traits. In table 2 some of the more prominent ones in each group are listed together for comparative study.

In summary, we have seen how overdevelopment of the same traits which are necessary to some extent and often highly desirable and useful in our present culture can in turn impair personality integration, decrease individual effectiveness, interfere with interpersonal relations, and interfere to some extent with one's ability to secure satisfaction in living. When these untoward sequelae occur, the feasibility of character analysis should be explored.

I have noted earlier the fine line which is present between the normal and the psychopathologic. This is particularly true when one is observing and studying personality traits. For example, what can represent thrift for one person might be considered parsimoniousness in another. Many traits are present normally. Character analysis can prove useful where actual psychopathology is very minimal. I have had the interesting experience of serving as the leader of 4 groups of Federal executives working together in a psychoanalytically oriented program of group training in human relations.[16] Each group consisted of successful normal executives who worked together from 2 to 3 years. Since participation required a degree of purposeful and sought-after self-revelation never even approached in any of the usual administrative situations, there was a selective process operative at the launching of each group which resulted in the elimination of less secure candidates. The personal benefits resulting in this group endeavor were in the nature of improved self-understanding, and, where modifications took place, they were mainly concerned with personality attributes.[17]

TABLE 2

Three Groups of Character Defenses

A comparative listing of defensive character traits in the three more distinct personality constellations.

THE HYSTERICAL PERSONALITY	THE DEPRESSIVE PERSONALITY	THE OBSESSIVE PERSONALITY
1. Egocentricity	1. Overseriousness	1. Orderliness
2. Emotionally capricious	2. Restricted sense of humor	2. Inhibition (actions, thought, imagination)
3. Immaturity	3. Lowered spirits	3. Stubbornness and obstinacy
4. Attention-seeking	4. Studiousness	4. Indecision and doubt
5. Flair for the dramatic	5. Compliance	5. Overconcern with detail
6. Susceptibility to suggestion	6. Subservience	6. Parsimoniousness
7. The "spoiled child" picture	7. Obsequiousness	7. Rigidity
8. Impulsiveness	8. Deliberateness	8. Preciseness
9. Intelligence, variable	9. Intelligence likely high	9. Intelligence likely high

There is a tendency in child-training for recapitulation of parental traits with at times a greater or lesser admixture of reaction formation, thus, the old and often accurate saying "like father like son" and "like mother like daughter." Parents take pride in having "a chip off the old block." Similarly, parents with obsessive traits may tend to encourage the development of similar traits in their children. Parents are further likely to be pleased by the emergence of traits which to them indicate early evidence of maturity. Certain obsessive traits are in this fashion encouraged and welcomed. Their possible overdefinition or hypertrophy in response to this is what becomes a matter of concern. W. E. Hickson's "Try and Try Again" has been repeated in many American homes to try to increase persistence and perseverance:

" 'Tis a lesson you should heed:
  Try, try, try again
If at first you don't succeed,
  Try, try, try again."

The formation of character traits is a highly complex process. Personality "is moulded by the varied sequence of experience,—by all the relationships effected, whatever their nature."[18] Brierley also pointed out the interdependence of personal and social conditions, while Sullivan[19] and others have stressed the importance of interpersonal relations in emotional development. Abrahams and Varon[20] in an interesting piece of group analytic research in "Maternal Dependency and Schizophrenia" have pointed up "the dovetailing of the defenses of mother and daughter (which) stood out in bold relief. . . ." Klein[21] relates obsessional defenses to manic defenses, to paranoid anxieties and as a result of a failure of "the act of reparation."

Scholars and psychiatrists have historically noted the great difficulty of seeing oneself clearly. With exaggerated obsessional character defenses as in other personality traits and items or patterns of behavior, the person concerned may be almost the last to see it. King David's anger as a described and specific variation of this problem has recently been named and presented elsewhere.[22] This thought brings us to considerations of treatment.

Treatment is indicated when any character traits are sufficiently marked or have developed out of proper perspective. In these circumstances they become handicapping. Accordingly, they may be a matter of concern to the individual affected provided he is at least aware of them. They may also be a source of concern to family, physician, friends, and professional or business associates. Consultation with an experienced psychotherapist can determine the potential results of treatment. Successful treatment must be investigative to achieve success. Patient and psychiatrist must work together to determine the psychologic needs which necessitated development of various character defensive traits. Actually, some of this is inevitably a part of every successful psychoanalysis regardless of the emotional condition present. Where indicated and feasible, psychotherapy of the obsessive group of character defenses can be successful and gratifying. Substantial benefits can seldom be achieved, however, on a short term or unintensive basis. Some further considerations in regard to treatment of the obsessive-compulsive defenses will follow in the next article in the series, entitled "The Obsessive-Compulsive Neuroses." Finally, it is clear that character defenses as they have developed in response to internal and hidden powerful psychologic needs have become an integral part of each individual. As such they operate automatically and are largely out of conscious voluntary control. They cannot be removed surgically as we might amputate an extremity, nor by logic or force. They can only be modified by the individual concerned voluntarily, when through greater insight he is ready and freely willing to forego some of the underlying psychologic needs.

SUMMARY

In this discussion of the obsessive personality I have attempted to outline a rather specific pattern of personality by presenting various descriptive and clinical data, together with some of the dynamic factors which enter into the development of obsessive character traits. In the introduction the ubiquitous incidence of various obsessive character defenses was pointed out. These traits include meticulousness, obstinacy, orderliness, overconscientiousness, indecision, and perfectionism. They serve similar psychologic purposes to obsessive neurotic symptoms which may appear in replacement or in addition to them when they are insufficiently effective or when new stress is added.

Following some historical notes about the development of scientific interest and inquiry into the obsessive-compulsive defenses, it was noted that present culture places a premium on the possession of a certain level of obsessiveness.

The presence of strong ambivalence and some of the influences of obsessive traits were noted as they entered into family, social, and professional relationships. Parts of 3 cases were summarized to illustrate several aspects of the obsessive personality. In table 1 a rather complete listing was made of the traits commonly associated with obsessiveness, and in table 2 a comparative listing was made of some typical personality traits in 3 distinct types of personality. In view of the widespread presence of obsessive traits and their frequent personal and social utility, the distinction between normal and pathologic is often a fine line between the balance of constructive effects of a trait versus its becoming handicapping, limiting, or self-defeating. With this group of personality characteristics in particular, the very traits which are constructive and useful by further development can often become limiting, nonconstructive, and self-detrimental. After noting briefly some factors in relation to often inadvertent parental fostering of obsessive traits, a few remarks were offered about treatment.

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President's Page

HSA THE TARGET

Organized in 1935 primarily through the activities of the Medical Society, Hospital Service Agency has been mainly intended to provide an economic balance between contributed and tax funds and the hospitalization needs of people without funds. It is intended also to be an agency which can assure physicians that their free services are dispensed to the truly medically indigent and to serve as a catalyst in promoting economic independence in the medically indigent.

It disburses at this time the hospitalization funds of four Community Chests and about six public welfare agencies in Washington and the surrounding area.

Recent proposals that its budget be made subservient to the Washington Community Chest would ignore the interests of the other agencies involved and are viewed with concern by the Medical Society.

The Medical Society deplores any attitudes in Washington which will serve to divorce the District of Columbia from surrounding areas in voluntary health activities.

Very likely operations of HSA have been made the target of various proposals in recent years primarily because in those years the Washington Community Chest has failed to meet its goals, has never made sufficient appropriations to the hospitalization funds, and has never recognized a rate sufficient to reimburse the hospitals for their costs for community-supported patients.

Herbert P. Ramsey

Editorials

MAN'S CRUELEST ENEMY

Cancer will at some time strike 1 in every 5 Americans, according to present estimates. It is estimated that 23,000,000 Americans now living will die of cancer if present rates continue. Last year, about 73,000 cancer patients who might have been saved died because proper treatment was begun too late, according to American Cancer Society estimates.

Each year the Cancer Crusade for funds is carried on during the month of April, and April, 1954, is here. This is the month when the District of Columbia Division of the American Cancer Society goes to the people of Washington for the money necessary to continue its threefold program of research, education, and service. Contributions to the Society are an investment in the future. Already great strides have been made in tracking down the causes and cures of cancer, but the ultimate job of completion is yet to be done. Lay people as well as the men and women of medicine must be further educated in detecting cancer, a task the Society is doing year-round. To the patient who suffers from cancer the services the Society offers come as much needed gifts of humanity. In many areas of the country, improvement in the diagnosis of cancer and its clinical management can be attributed in large measure to the American Cancer Society's training program through fellowship grants. Ultimately the expected cure for cancer will be attained—that is inevitable—but the way to that goal is marred with disappointments that must be met and conquered.

The symbol of the Society is the sword of hope—a crusader's blade with the handle adapted from the medical Caduceus. This is your symbol, for you are the American Cancer Society. Your contributions through this organization will help bring about the end of *Man's Cruelest Enemy*.

Raymond T. Holden, M.D.
Chairman, Medical Committee,
District of Columbia Division
of the American Cancer Society

"LET'S EXAMINE THE FACTS"

Each year the American public donates large amounts of money to the fight against cancer. This money is allocated to cancer research, treatment, and education. Some of our finest research men, physicians, equipment and facilities are being expended to advance methods of treatment of the various types of cancer. It is a slow, laborious process, but definite progress is being made. The returns from this investment of time and money can be reached to the fullest extent only if proper cancer detection methods are used widely and intelligently by the practicing physician.

More patients than ever before are consulting their physicians for symptoms suggestive of malignancy. The message of the American Cancer Society is beginning to bring results. The public is now cognizant of the danger sig-

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia.

nals of cancer and expect their physicians to be appropriately prepared to "carry the ball" from there on.

During the coming year approximately one quarter of a million American people will be stricken by cancer. Fifty per cent of these can be saved if properly examined when symptoms first appear. Present-day educational programs, research grants, and supported tumor and cancer clinics throughout the country supply the physician with the best methods available for early diagnosis and treatment. Unfortunately they are not always utilized to their fullest extent. No number of cancer detection centers will change the fact that most patients with premalignant or malignant lesions are seen first by their family doctor, and it is he who should function as the cancer detection clinic.

Patients should be educated to the necessity of periodic complete physical examinations, chest X-ray films, and endoscopic and laboratory studies. Women should be instructed in correct self-examination of the breasts and the necessity for periodic pelvic examinations. If these measures cannot be carried out in the physician's office, then appropriate referral to any of the available coöperating detection clinics should be the next step. Intelligent cooperation between the private physician and appropriate clinic facilities will lead to better patient care and earlier cancer detection.

Constant education has alerted the American public to the 7 danger signals of cancer and has concomitantly decreased mortality and morbidity. Proper and prompt cancer detection can do even more.

BRUCE I. SHNIDER, M.D.
Director, Cancer Detection
Clinic, Georgetown University
Medical Center

WHAT A PHYSICIAN SHOULD BE

When a man has been in private practice for more than 25 years and has made a success of it, you might think he would have some good advice for those who have still to set out on their careers. You'd be right in the case of Dr. Julian Price of Florence, South Carolina. Recently, he had occasion to talk extemporaneously to a group of medical students. He had no manuscript—not even a note—and his speech was not recorded. Here's approximately what Dr. Price had to say about what a physician should be.

First, a physician should be well trained. Nowadays, the medical schools and internships and residencies take good care of that. When a doctor is ready to start practice, the chances are he's well prepared scientifically.

Second, the kind of physicians worth having are those who will keep up with scientific and other advances in medicine. There are plenty of opportunities for them to do this—good medical journals and fine meetings—but often there is insufficient motivation. It's so easy not to keep abreast; there are so many distractions that you must kick yourself to make you do it.

Third, a doctor needs a large amount of the spirit of skepticism. There's a tendency during training days in school and just afterward for doctors to think that their stock of information is without parallel. They know it all. Fortunately, most of them outgrow this tendency, at least to some extent. This may come about when a doctor suddenly realizes that an authoritative source for information like a brand new textbook is far out of date when it's first published. Or skepticism may be fostered when the unexpected happens. An example is the case of the young resident who was instructed by his professor to administer Mercurochrome intravenously to a patient having puerperal sepsis. (This was in the days before there were any good chemotherapeutic agents for such infections.) A couple of days later the patient's temperature was normal and she was much improved. Seeing her again on ward rounds, the professor was elated. He exclaimed, "It worked!"

"What worked?" asked the resident.

"The Mercurochrome, of course," replied the professor.

"Oh that," said the resident, "I forgot to give it."

In some kinds of practice in some places, skepticism is especially important. Certainly that's true in pediatrics, particularly in the "sticks." So, keep a question mark in your mind all the time. Don't ever suppose that the final answer is in.

Fourth, doctors need to be patient-minded. It's a common criticism that doctors think too much about their own comfort and welfare and the money they make, and not enough about their patients. We need doctors who think primarily of their patients. Remember, when a doctor responds to a patient's call at 2:00 a.m., that's not news; when he doesn't, that is news!

Fifth, doctors must have character. It's easy for a physician to pull a fast deal, to get away with untruths, to be not exactly honest. An example we hear about now and then is the doctor who gets caught in an attempt to evade payment of income tax. Fortunately there are not many crooked doctors. But there is a small group who give the profession a black eye. We need to get rid of them, and we need to be sure that newcomers to the profession are men of integrity and character.

Sixth, the medical profession should be made up of men who are not afraid to take their place in the community. Our Nation is founded on community life. This has advantages for all of us, and it creates special obligations for some of us. Those in the medical profession must remember that they are not just physicians—they are citizens too. The average medical student never thinks about this, but when he goes into practice he must do his part as a citizen in support of schools, the Boy Scouts, philanthropic organizations, and all the other parts of life in the community in which he lives and practices. The attitude of other people toward the medical profession depends upon what individual physicians do in their practice, but it also depends upon what these men contribute as citizens.

Editorial comment on Dr. Price's remarks would be gild for the lily. Let this end with the thought that Dr. Price does more than talk about things like these. His career in medicine is a vital example of what a physician should be.

H. H. H.

MEDICAL WITNESS—THE GENERAL PRACTITIONER

"I have to go to court on a case tomorrow!" How often have I heard this spoken with much trepidation and fear by the general practitioner these past few years. You, the reader, probably have said the very same thing with a little nervous heat wave disturbing your usual calmness. If the general physician would remember a few basic principles pertaining to the medical witness, adhere strictly to the facts in the case presented, and present those facts to the best of his knowledge in concise down-to-earth terms, how much easier his job as medical witness would become.

You must keep in mind that the purpose of any lawsuit is to ascertain the facts, that is, the truth. For the general practitioner, as a witness, the facts of the art and science of medical practice should be presented to the judge and jury (who must be enlightened by your down-to-earth description) in language they can understand. How are they (judge and jury) to decide if they do not comprehend your language? It is sometimes advisable to make your point in medical or surgical language, then follow it up with an understandable interpretation for the jury or judge, or both. In this manner, you will be much better appreciated and received. Do not confuse your listeners with medical jargon.

Know the facts and all about that which you will be asked. Refresh your memory on the anatomy of the parts in question, and on the nerve and blood supply, the normal and the abnormal. Show, and have ready to view if possible, X-ray films of before and after. And if the field is beyond your scope, bring with you a volume by some authority, and receive permission of the court to quote from the expert in this book; sometimes this is granted.

A case in point was the injury sustained by a patient when struck by an automobile while crossing the street. This patient sustained a ventral (abdominal) hernia, created by the severe impact to an already weakened and lax abdominal musculature. The question arose in court, could trauma create this hernia. The physician, a general practitioner, was asked if he were a "hernia expert." He certainly was not, and so replied. He also stated that there was not a hernia expert per se in the entire city; but to substantiate his testimony he had carried with him a new and up-to-date volume on surgery. The general practitioner asked, and received permission from the judge, to refer to the "hernia expert" in this volume. The physician read to the jury the exact words of the "expert" from the volume whereby trauma could cause this hernia. The simplicity and honesty of this general physician, not trying to make of himself an expert, yet having ready and at hand expert testimony, helped to win a favorable decision in this case.

Whenever you have acquired knowledge of the facts of a case in which you have treated a patient and subsequently are called upon to testify, you must do so, even though in treating the patient in question you had no thought of subsequent lawsuit. This is one of the risks and duties incident to our professional life.

It is unfortunate that many general practitioners rarely have consultation with the patient's attorney prior to the day of trial. This lack of coöperation creates a grave hardship for the physician and in many cases stunts his testimony. Insist on pretrial discussion with the attorney. These discussions will make you a better witness, and even a better trial-physician.

Learn thoroughly the facts in the case, but these will be of no avail if your records, which you will be asked to bring to the courtroom, are not complete and clearly written.

If you have not seen nor examined the patient in question for some time previous to the trial, call the patient's attorney and insist that this patient return for examination, so that you will know exactly what residuals, if any, are present. Much can change in the body in 2 or 3 months since your last examination and the date of trial. One question asked by competent and experienced attorneys in 99 per cent of lawsuits dealing with bodily injury is, "Doctor, when did you last examine this patient?" Remember that hearsay, that is. what the patient tells you, is not admissible, for only the facts, the actual physical findings on examination, response to treatment, and the residual defects you see or elicit by examination, are acceptable.

If you have been asked to examine a patient by the patient's attorney or an insurance company, and after getting the facts you feel that the patient has no legitimate case, or you do not have faith in what he tells you, convey your feelings to the patient's attorney by telephone, and remove yourself from the case.

Basically, to be a good medical witness requires attention to the following list of do's and don'ts:

1. Tell the truth.
2. Come prepared.
3. Don't be afraid, but be modest and natural in actions and speech.
4. Listen to questions, and answer only what is asked.
5. Admit if you don't know. Don't hedge or become flustered.

6. Speak up, be courteous, do not lose your temper, and do not be belligerent.

Always remember, that once in the courtroom the lawyers for both the defendent and plaintiff are in command. You are on unfamiliar ground and just another person present to answer questions to the best of your medical and surgical ability and knowledge.

I. PHILLIPS FROHMAN, M.D.

In and Out of Focus

BY THE OBSERVER

Is This the Formula? On a number of occasions in the past several years, mention has been made in this column of the decline in attendance at medical meetings. This situation, it has been pointed out, is not peculiar to any one community for it is one which confronts most medical organizations, especially those situated in metropolitan centers.

The Medical Society of the District of Columbia is unique in that while it is a state medical society it functions in many respects as a county medical society. In its dual capacity it holds what is known as the ANNUAL SCIENTIFIC ASSEMBLY, which, in its essentials, is similar to the annual meeting of a state medical society. For more than seventy-five years the Society also held weekly meetings. These were reduced to twice-monthly during World War II. At the War's close an attempt was made to resume weekly meetings but interest flagged and the Society returned to twice-monthly meetings, which were finally abandoned for the three-day Midwinter Seminar.

The Seminar got off to a shaky start in 1951. Interest in it was disappointing and this was reflected in the attendance. Indifference was ascribed largely to the fact that, in contrast to the ANNUAL SCIENTIFIC ASSEMBLY, speakers were all local physicians. It was also said that the subject matter was of limited interest, and day sessions were inconvenient for busy practitioners. Significantly, all those who attended the Seminar had high praise for the program. Whatever the reason for the lukewarm reception, officers of the Society decided that the Seminar should be given another chance. The second Seminar received a much better reception than the first. The fact that night meetings had been substituted for day sessions explained in part, it was believed, the increased attendance. At any rate, the Society's officers were encouraged to make another try.

The Third Midwinter Seminar was supplemented by monthly meetings. These were suggested by the President of the Society, Dr. Herbert P. Ramsey, because he felt that the Medical Society members were getting out of the habit of coming to the Society's building. This he thought regrettable because it always had been the center of medical activities in Washington. The Board agreed with him and requested the Program Committee to include these meetings in its plans.

It is a pleasure to report that both the Third Midwinter Seminar and the monthly meetings have succeeded in attendance and interest beyond the most optimistic expectations of the Program Committee. In fact, the Third Midwinter Seminar turned out to be one of the most successful scientific meetings in the Society's history, and takes its place with the ANNUAL

Scientific Assembly from the standpoint of attendance.

On the first evening of the Seminar the auditorium, which has a seating capacity of 486, was filled to near-capacity. Although the attendance fell off some on the second and third nights, it was still better attended than any meetings in recent memory.

For the benefit of those who were not present at the Seminar, the subject under discussion was Diseases of the Liver and Biliary Tract. Except for Dr. Franklin McCue Hanger, Professor of Medicine, Columbia University College of Physicians and Surgeons, who was Moderator at all sessions, the program was presented entirely by physicians practicing in the District, members of the faculties of George Washington University and Georgetown University medical schools, and medical officers in the armed forces stationed in the Nation's Capital.

What had happened to raise the Seminar from an indifferently received medical meeting to an unqualified success? Had the planners discovered the formula which the Society had so long sought? It occurred to your Observer that the answers to these questions were worth seeking—that they might be helpful to succeeding program committees.

Logically, your Observer turned to those who best could answer his questions. He went first to Dr. Hugh H. Hussey, Chairman of the Program Committee, and elicited from him the following observations:

The Seminar's success this year indicates preference for the clinical conference or grand rounds type of program. The subject matter, too, held appeal, but he doubted if didactic lectures would have proved as attractive to physicians as panel discussions.

He was and he wasn't surprised at the enthusiastic response. There is always the uncertainty before a program is presented as to how it will be received. On the other hand, he was highly elated when he first saw a copy of the program planned under the direction of Dr. Thomas M. Peery, Professor of Pathology and Director of Postgraduate Instruction at George Washington University Hospital, who is a member of Dr. Hussey's Committee.

Panel discussions had generally been popular with doctors. This is the type of program they want and will come to hear.

Dr. Peery, who, more than anyone else, was responsible for the program, had this to say:

He agreed with Dr. Hussey that the panel discussions were most popular at this time. However, he felt that this year's program appealed particularly because it was on one subject. So often programs are disconnected, there being few topics in which a physician might be interested. In this instance, if the subject interested the physician at all he was inclined to attend all the sessions. The one-subject program was pioneered by the New York Academy of Medicine and has been adopted with considerable success throughout the country.

He thought that the choice of the subject matter did make a difference but other subjects might have been just as well received. Broad coverage of the subject, including its basic science as well as the clinical features, increased its appeal.

Considerable credit was due Dr. Hanger for the Seminar's success, for it was he who gave the meeting cohesion.

Finally, the use of the case histories gave the discussions a graphic quality which otherwise would have been missing. It also broadened the interest in the meeting to include physicians in all the specialties.

While there was no question that panel discussions are at present popular, it is improbable that their popularity will last. No program formula, he thought, would appeal to physicians indefinitely.

These interesting observations add up to the fact that successful program chairmen, and their committees, are those who have sound medical knowledge, courage of their convictions, and possess that indefinable quality—showmanship.

A New Factor

On March 11 the Administration introduced companion bills in the House (H.R. 8356) and Senate (S. 3114) to implement its program to reinsure medical prepayment plans. This legislation has been "in the works" for several weeks during which time Mrs. Oveta Culp Hobby, Secretary of the Department of Health, Education and Welfare, and her associates had consulted many experts, including representatives of the American Medical Association.

On the date the above bills were introduced, Mrs. Hobby held a press conference. She had this to say about the reinsurance program:

> "Through a Federal reinsurance service, nonprofit health service organizations and private insurance companies would be encouraged to enter new areas and to offer greater protection. The objective is to further experimentation in new types of insurance policies, benefits and coverage.
>
> "Reinsurance can help accomplish this objective since under it, an insurance carrier may be willing to experiment with marginal actuarial risks and with new types of risks that it might not wish to assume alone.
>
> "Although the full results of this proposed program cannot, of course, be forecast, we believe these might be some of the accomplishments:
>
> —broader health insurance coverage;
>
> —a reduction in the present number of exclusions from coverage under certain types of health policies;
>
> —more comprehensive benefits with respect to the total limits of health insurance in order to reach more effectively into the areas of catastrophic illness;
>
> —an increase in the number of days of hospitalization paid for by insurance;
>
> —elimination of certain of the age restrictions in policies so that more older persons may continue to have the protection of health insurance;
>
> —the possibility of providing insurance for certain individuals now considered uninsurable;
>
> —development of health insurance programs that will be realistic in terms of paying the costs of early diagnosis and treatment of chronic diseases.
>
> "While we believe that this plan holds great promise for the American people, I want to mention three limitations:
>
> "First, the reinsurance service will help only those who can and are willing to include health insurance premiums as a necessary part of the family budget, and those who are covered by insurance plans maintained by their employers in whole or in part. I should like to point out, however, a significant fact. According to a recent survey, 25 per cent of the individuals in families with annual incomes under $2,000 have some form of health insurance.
>
> "Second, although the plan may not immediately solve some of the problems of coverage for the aged, another study shows that 26 per cent of the people 65 and over in the noninstitutional population have some form of health insurance.
>
> "Third, the success of the plan depends on the willingness of health service and insurance organizations to use the reinsurance service and to assume new and broader risks.
>
> "Despite these limitations—and they are limitations—we believe that the reinsurance programs should be of considerable help in speeding our progress toward the health goals which we all share."

Essentials of the proposed program are as follows:

Private insurance companies, voluntary nonprofit organizations, such as Blue Cross and Blue Shield, and other voluntary groups are eligible to participate if they comply with requirements, and if they are approved by the Secretary.

The Secretary will determine the conditions under which insurance plans may participate, taking into consideration their objectives, including the extension of coverage to persons not now protected, the extension to new geographic areas, and provision of benefits and services not now readily available.

Plans will not be approved unless they are (a) financially sound, (b) operating in accordance with state laws, and (c) deemed worthy of public confidence.

The Secretary will determine minimum benefits and waiting periods and establish safeguards against undue exclusions such as preexisting conditions or specific illnesses.

Plans of given kind or type can be reinsured only if reinsurance on comparable terms and conditions is not available from private sources.

The Secretary will maintain a technical, advisory and information service to assist health insurance plans without cost. This service will also conduct studies and collect and distribute information on the organizational, actuarial, and other problems of health insurance.

Reinsurance plans will be protected against abnormal losses up to 75 per cent.

Reactions to this program have not been pronounced, one way or another. Some experts have expressed the view that it is conservative to a point where its effectiveness, should it be adopted, is dubious.

Another development of much more significance to the medical profession of Washington was the announcement by President Eisenhower of a proposed pay increase for Government employees. In addition to pay boosts he recommended fringe benefits including a contributory program of medical and hospitalization insurance. One half an employee's premiums, up to $26.00, would be paid by the Government. Should the employee's premiums exceed $52.00 per year, he would be expected to pay the additional amount himself.

Coverage would be available to both the employee and his family, with the option of selecting the organization supplying the hospital, medical, or surgical benefits, or all three.

Coverage could be sought from either commercial companies or nonprofit associations.

The program would be underwritten by the Government to the extent of approximately $50,000,000 per year.

Details of the program are being worked out by a fact-finding committee of Federal officials including representatives of the Department of Health, Education and Welfare, the Treasury Department, Budget Bureau, General Accounting Office, and the Civil Service Commission. This group will confer with industry, Blue Cross and Blue Shield Commissions, unions, and others. Later on the Commission will draft legislation to carry out the contributory program.

At the time this is written, it would appear that action on these proposals at this session of Congress is questionable. It seems probable that no action will be taken on the program until next year.

Obviously this program has special significance for Washington's Blue Shield and Blue Cross plans. Enrollment in Medical Service on December 31, 1953, was 404,034, and in Group Hospitalization 554,768. A substantial number of subscribers in both plans are Government workers.

Should the President's proposals become law, competition between commercial insurance companies and nonprofit plans for these subscribers will undoubtedly become more acute than it is at present. It is conceivable, if they are permitted to do so, that some commercial companies will forego their profits in an effort to insure Government employees on the group basis.

It has been suggested by an official of a nonprofit plan that the situation demands that Blue Shield Plans take a more realistic attitude toward income levels, that they will have to be liberalized if the plan is to hold its own. Perhaps a sliding scale of income levels and premiums is the answer.

These observations are, for the most part, only conjecture. One thing is certain, however, the President's program, if adopted, will vitally affect, not only Medical Service and Group Hospitalization, but every physician in the District of Columbia.

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"This Is the First Time—" Physicians here as elsewhere throughout the country are understandably concerned about the increase in malpractice suits. Unhappily, the District of Columbia is among a half dozen cities most plagued by such litigation. Records of the insurance company which writes most of the professional liability insurance in the District reveal that 21 claims were filed against District physicians in 1940, 66 in 1950, 67 in 1951, and 83 in 1953.

The situation locally has reached a point where one frequently hears a distressed physician protest: "This is the first time I have ever had any difficulty with a patient. I never dreamed that he was dissatisfied. In fact, he led me to believe that he was particularly well pleased with my services. What has happened to people, anyway?"

One thing has become apparent. There is no one solution to the malpractice problem. Here are a few of the reasons:

¶ People, generally, are more suit-conscious than they have ever been. This is reflected in the experience of insurance companies writing all forms of liability insurance. An example is the avalanche of claims due to automobile accidents and the resulting spiral of premium rates.

¶ What appears to be the sympathetic attitude of the courts toward those seeking damages. Juries, particularly, it seems, are swayed in their decisions by the knowledge that an insurance company will foot the bill.

¶ The erroneous belief that medicine is an exact science; that if proper treatment is given, nothing can go wrong.

¶ The inexpertness of some physicians who undertake procedures which they are not qualified to do.

¶ Careless statements by some physicians about their colleagues and their professional skill. This has been estimated to be the cause of between 25 and 30 per cent of the claims filed.

Physicians are also held responsible for mistakes in judgment and neglect. But these can be classed as the basis for a comparatively small percentage of the claims.

The question naturally arises, what can be done about this situation? One can only conclude that if it continues to deteriorate, doctors will become more reluctant to use procedures where there is an element of risk for fear of inviting suit should the results be less than hoped for. This would be a regrettable development, to say the least.

Prevention, it would seem, holds more promise than any solution offered thus far. Recently, the advisability of establishing a pretrial commission, such as was suggested to the Society a year ago and rejected, has been revived. While details have not been worked out, it is contemplated that the commission would adjudicate claims against physicians charged with malpractice. Both parties to a complaint would be required to agree in advance to abide by the decision of the commission, which would be an unofficial body composed of an even number of attorneys and physicians, and chairmanned by a layman.

There are, of course, many difficulties in the path of establishing such a body. These are now being studied by a joint committee of the Society and the District of Columbia Bar Association. At a recent meeting both groups agreed that their objective is to develop a plan by which unjustified or nuisance claims against physicians can be eliminated and a substantial number of other claims adjudicated to the mutual satisfaction of all concerned.

Until better methods are developed, physicians can do much to improve the present situation by observing the following rules:

Do not guarantee the results of your treatment.

Do not undertake treatment for which you have dubious qualifications. The law requires that you have the knowledge and skill commonly possessed by other members of the profession performing a similar service in the community.

Refrain from making overoptimistic statements concerning a patient's recovery.

Anticipate a patient's desire for consultation. If he, or those responsible for him, is dissatisfied, turn him over to another physician. Keep a meticulous record of each patient. Any failure on the part of the patient to comply with instructions or failure to keep an appointment should be entered in the patient's record. A good practice is to notify the patient by letter of his failure to appear for an appointment.

Where a surgical operation is to be performed or the treatment to be given involves certain dangers, obtain a signed consent from either the patient or the patient's guardian. Before obtaining such consent, outline the surgical procedure to the family or guardian. This will vitiate any claim on the part of the family or guardian of a lack of knowledge.

The same precaution with respect to obtaining signed consent should apply in the matter of autopsies.

Medical records should be kept for an indefinite period. The statute of limitations in the District of Columbia is three years where a tort is involved. In medical cases this could vary. It could start to run at the time of the alleged malpractice, or at the last date of treatment, or when the individual feels he has been injured and decides there is basis for a malpractice suit.

Where a malpractice suit seems inevitable, contact the claims department of the insurance carrier. Provide the department with a memorandum containing the complete history of the case, all details of past relationship with the patient, and what has been done for him.

In a communication bearing upon the malpractice situation in Washington, dated March 5, 1954, Mr. W. M. Bucher, Executive Secretary of the Hospital Council of the National Capital Area, requested the Society to convey the following suggestions to physicians:

"1. Write specific orders, giving the correct name of medication and amount, strength of solutions to be used, frequency of administration, where and how the preparation is to be administered. All internal medications should have the route of administration indicated: P.O.—I.M.—I.V.—S.C., etc.; external medications, the area to which applied.

2. Use the metric system in writing dosages in order to avoid errors that result from converting the dosage to milligrams, etc.

3. The patient's chart should be legible and intact. If an order is written incorrectly, do not erase or mark it over with ink, but draw a line through the order and write beside it 'error,' then proceed to write the correct order. No part of the chart should be destroyed for any reason whatsoever.

4. Do not change a written order that has aready been carried out. If the dosage of a medicaton is to be changed, write a new order.

5. In writing the order 'Resume orders' postoperatively, be sure to check carefully all orders written previously.

6. Do not ask the nurse to take a verbal order except in cases where the patient's life depends upon speed in instituting therapy; then, please write orders for those verbal orders given.

7. Standard abbreviations only should be used; there is a ready reference at each nursing station to facilitate checking of abbreviations.

8. If a new preparation is being ordered, please inform the house staff and the charge nurse on duty; frequently much time is consumed by the pharmacist and others in trying to locate drugs that may not be available here. Some information about that new drug would be greatly appreciated by those having to administer it for the first time."

As previously stated, until better methods are established for dealing with the malpractice situation, members should adhere to the above rules. Results will more than justify the time and effort required to comply with them. It is also within the realm of possibility that if physicians generally coöperate, no further steps will be necessary.

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The AMA's Public Relations

On an evening some weeks ago your Observer was discussing medical problems with a physician prominent in the affairs of organized medicine. In the course of the conversation the frequent criticism of the American Medical Association came under discussion, the physician expressing concern at its intensity in certain quarters. Finally, he posed the question, "What is wrong with the AMA's public relations, anyway?"

As is usually the case, your Observer was not short on opinions, most of them familiar to readers of this column. In candor, he must admit they made little impression on his questioner.

On the following evening, when this column was in process of preparation, he had opportunity for reflection on what had been said. The result, he thought, might interest his readers.

First of all, there is nothing wrong with the AMA's public relations, if one has in mind the Association's department concerned with this field. It is expertly conducted by well qualified individuals. The material, which is now widely disseminated under its direction, is, in the opinion of your Observer, dignified, thoughtfully prepared, and interestingly written.

These observations, however, are concerned with the broader aspects of the AMA's public relations. After all, the department at the Chicago headquarters is charged with the responsibility of conveying to the public, in a manner which will win friends for the AMA, the Association's policies and its varied activities. There its responsibility ends.

As is well known, the AMA is a large and powerful organization, not only in the field of medical science, but in politics. In the latter field it has taken a positive position on a number of controversial matters. In so doing, it has made enemies, some of them in positions of considerable importance. Lost sight of in the heat of the controversies in which it has been involved have been the AMA's constructive program and its outstanding contributions to public welfare. This is something which loyal supporters have deplored and have hoped could somehow be corrected.

The AMA's role in domestic affairs is somewhat analogous to that of this country in world affairs. The very fact of our country's size and strength and its positive views, frequently unpopular abroad, have been the cause of much friction and criticism. Overlooked under these circumstances are its many generous and unselfish acts.

Lest this analogy seem too pat, it must be admitted that at this point differences become apparent. Both have made mistakes, some of them grievous ones. But while public officials do not hesitate to admit the country's mistakes, the AMA gives the impression in widely publicized utterances that it admits to no errors.

Of course no country, organization, or individual is infallible, and its mistakes, admitted or not, are capitalized on by opponents. The most effective manner for an organization to counteract them is to admit frankly that it is only human to err, and to direct attention to those things which are to its credit.

Just as the conduct of our citizens abroad makes or loses friends, what the doctor says and does in his daily contact with patients is of vital importance where the AMA's public relations program is concerned. What, then, is his relationship to the AMA? Is he sympathetic to its objectives? What does he know about its program?

Observation leads to the belief that he knows very little about the program, in fact, so little that he frequently cannot discuss it intelligently. What opinions he holds are often based on what he reads in the press. As a result he is often critical of his organization. He regards the AMA as a negative force and asks such questions as, "Why has the AMA never consulted me about matters of policy?" "Why hasn't a poll been taken to ascertain the views of the medical profession in regard to matters about which they read in the newspapers?"

The fact that there is detailed information about current medical issues available through the *Journal of the AMA*, and other sources, makes little impression upon him. Reasonable or unreasonable, he expects this information to be transmitted to him on a more personal basis.

If there is any criticism on this score, it should not be directed at the AMA, for this is the responsibility of state medical societies. After all, they have elected delegates who are chosen not only to represent the organizations in the deliberations of AMA's House of Delegates but to keep their constituents informed of what it does.

This brings your Observer to the crux of these comments and that is that our Society's delegates have themselves recognized the validity of this reasoning, not that they have been derelict in their duties, for they have ably represented the Society and, following each meeting of the House, their reports have been published in the ANNALS. Nevertheless, they have felt that more should be done to enlighten members, and with the Executive Board's approval, time is being set aside at the Annual Business Meeting for the discussion of current medical problems which may or may not have been discussed in the House. Members will be invited to ask questions and discuss problems, and to offer their suggestions.

This is a step which, if the participation is as general as is expected, will not only be productive of better understanding but give the delegates an indication of the Society's wishes.

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House Officers' Contest

On March 25, 1942, the Program Committee initiated what was then something new in the way of programs, House Officers' Night. Its purpose was to stimulate the participation of residents and interns in an essay contest. Prizes, it was decided, should be choice medical volumes.

In an issue of the MEDICAL ANNALS which followed this program, your Observer commented that, although the attendance was disappointing, those present were well rewarded. More enthusiasm had seldom been shown for papers at a scientific meeting.

As with so many other Society activities, World War II intervened and House Officers' Night was not repeated until March 23, 1949. Again there was enthusiasm but not the turnout that might have been expected. In view of this mixed reception succeeding program committees have apparently been reluctant to continue the program. At any rate, its revival has not since been suggested.

During its annual meeting last January, the Editorial Board of MEDICAL ANNALS expressed regret that House Officers' Night had been abandoned. It agreed that the papers presented in connection with the Night had been excellent. Especially commendable was the program's stimulus to house officers to do clinical research and to write. Too few physicians, they said, are interested in doing either.

At the conclusion of its discussion, the Board voted to recommend to the Executive Board of the Society that it revive a House Officers' Night in a somewhat different form—that it sponsor a House Officers' Contest in which residents and interns would be invited to submit original papers on scientific subjects. These would be reviewed by the Editorial Board who would award cash prizes for the three best papers submitted.

At its meeting on February 8, 1954, the Executive Board approved the Contest and authorized an expenditure of $150.00 for prizes.

The Editorial Board has decided to delay the Contest until after July 1, 1954, when new residents and interns are assigned to local hospitals. Details of the Contest will, therefore, not be announced until sometime in the summer.

T. W.

IMPOUNDED ANIMALS AVAILABLE FOR MEDICAL RESEARCH

After two public hearings, the Board of Commissioners of the District of Columbia, by virtue of Order No. 54-398, dated February 23, 1954, has declared it the policy of the District of Columbia Government to make available, for purposes of medical research and instruction at approved institutions, impounded animals which otherwise would be destroyed. The Medical Society of the District of Columbia was represented at the hearings by Dr. Herbert P. Ramsey, President; Dr. William P. Herbst, Chairman of the Committee on Public Policy; and Dr. Frederick C. Fishback, who has ably represented the Society for many years at Congressional hearings on antivivisection legislation.

The Commissioners have established an Animal Allocation Board which shall consist of one representative from each institution which has been approved by the Board as eligible for obtaining animals from the D. C. Pound for purposes of medical research and instruction, one representative from the Department of Public Health, one representative from the Metropolitan Police Department, and such other members as the Commissioners, from time to time, may appoint, but including at least three members from among the public at large who are interested in animal welfare. Members of the Animal Allocation Board shall serve without compensation, determine their own organization, and name their own officers.

The functions of the Animal Allocation Board shall be to advise the Commissioners in making policy determinations regarding the use of impounded animals for medical research and instruction; to assist the Director, Department of Public Health, in developing standards and criteria for licensing institutions that desire to avail themselves of impounded animals for research and instruction purposes; and to establish schedules, for use by the Poundmaster, for the equitable allocation of animals among approved institutions.

By "institution" is meant any school or college of medicine, dentistry, veterinary medicine, or agriculture, medical diagnostic laboratory, hospital, or other scientific, educational, or governmental establishment located within the District of Columbia or its metropolitan area, which under the faculty or other responsible officers thereof is engaged in the investigation of or giving instruction in the structures or function of living organisms, the causes, prevention, control or cure of disease, or abnormal conditions of human beings or animals; or is engaged in the testing and diagnosis of laboratory specimens, or the improvement and standardization of pharmaceuticals and drugs, by means of experimentation on live vertebrate animals.

Any institution, so defined, which desires to obtain animals that have been lawfully impounded shall apply to the Director, Department of Public Health, for a permit. All permits are issued subject to the approval of the Board of Commissioners; they shall expire automatically on June 30 of each year but may be renewed upon application to the Director of the Department of Public Health. Institutions which have been granted permits become eligible to procure live animals as long as they hold valid permits and conform to all the provisions imposed by Order No. 54–398 and by the Director of the Department of Public Health.

In order to provide for equitable allocation of impounded animals to approved institutions, the following procedures shall be followed:

1. When animals brought to the Pound are wearing any identification of ownership, the owner shall be immediately be notified by telephone or postal card.

2. All animals received at the Pound which are critically injured, dangerously ill, or which appear to be suffering from a communicable or infectious disease, shall be inspected by a qualified veterinarian; if there is no justification for trying to save the animal, it shall be humanely killed, provided that the owner, when identification of ownership is available, is notified immediately and does not elect to arrange for care, treatment, or other disposition.

3. Impounded dogs bearing identification of ownership may be redeemed by a bona fide owner on the payment of $2.00 redemption fee, or may be sold for $2.00 after 48 hours from the hour of a telephone notification to the owner, or 96 hours from the hour of mailing postal notification. Impounded dogs bearing no identification may be sold to individuals after 96 hours from the hour of impoundment.

4. Approximately the same provisions for redemption or sale of dogs apply to the redemption or sale of cats, except that the amount of payment is $1.00.

5. Only impounded dogs and cats which have not been redeemed by a bona fide owner or sold to a person by 5 p.m. of the tenth calendar day from the day of impoundment shall be subject to requisition by licensed institutions at a cost of $3.00 per dog and $2.00 per cat.

6. All animals which are subject to requisition by licensed institutions shall be allocated to such institutions at a ratio of 75 per cent of the total available at any one time to approved colleges and universities and 25 per cent to all other approved institutions. However, the colleges and universities may, from time to time, at their discretion, relinquish their established quota of 75 per cent of available animals, either in whole or in part, for allocation among other institutions.

7. Each institution shall provide for the transportation, at its own expense, of animals requisitioned from the D. C. Pound. For institutions located in the District of Columbia, the Pound will

PRESIDENTS' NIGHT 1954

Medical Society's Building, April 23, 1954, 8:15 P.M.

"These I Have Seen"
A Pictorial Presentation of Medical Washington

HERBERT P. RAMSEY, M.D.
President, The Medical Society of the District of Columbia

An excellent musical program and splendid entertainment will be furnished by members of the Medical Society and their wives

This is the first Presidents' Night since 1940

ACKNOWLEDGE YOUR INVITATION PROMPTLY

provide transportation, within the limits of available facilities, for a nominal fee.

8. The Poundmaster, D. C., shall serve as representative of the Animal Allocation Board with responsibility for assisting said Board in the performance of its function of allocating animals to approved institutions, including the maintenance of appropriate records regarding the disposition of all animals to licensed institutions.

9. All animals that have not been redeemed by a bona fide owner or sold to a person or are not being held for sale, as provided in the Order, and that have not been requisitioned by a licensed institution, shall be humanely killed.

For the purpose of insuring the humane care, treatment, and use of all animals in experimentation at approved institutions, the following requirements shall be applicable:

1. In any operation likely to cause greater discomfort than that attending anesthetization the animal shall first be rendered incapable of perceiving pain and shall be maintained in that condition until the operation is ended. Exceptions to this rule shall be made by the Director of the Institution alone and then only when the anesthesia would defeat the purpose of the experiment. In such cases the anesthesia shall be discontinued only so long as essential to make the necessary observations.

2. Where continuance of an animal's life is necessary to determine the result of an experiment the operation shall be conducted with appropriate precautions comparable to those used with human beings and appropriate care shall be taken to minimize discomforts during convalescence.

Accompanying its Order No. 54–398, the Commissioners have promulgated standards and detailed regulations for the purposes of insuring humane care, treatment and disposition of impounded animals, and for enforcing the provisions of the above relevant to licensing institutions that desire to avail themselves of impounded animals for research and instruction purposes.

INTERIM REPORT OF THE EXECUTIVE BOARD*

As is customary at the March Business Meeting, only the most essential business is presented. A comprehensive report of the activities and actions of the Executive Board and the Society's committees will be submitted for your consideration at the Annual Business Meeting to be held on May 5.

Dr. Frank B. Berry Proposed for Honorary Membership: Your Board deems it a privilege to submit this proposal, for Dr. Berry is one of the country's most distinguished surgeons. He was recently appointed Assistant Secretary of Defense for Health and Medical Affairs to succeed Dr. Melvin A. Casberg, who is also an Honorary Member of our Society.

Dr. Berry received his Degree in Medicine at Harvard Medical School in 1917. His internship and residencies were served at City Hospital and Peter Bent Brigham Hospital, Boston, Presbyterian and Bellevue Hospitals, New York City. Subsequently he became Consultant in Surgery at Roosevelt Hospital, New York, Fitkin Memorial Hospital, Jersey City, Methodist Hospital, Brooklyn, and many other institutions.

Dr. Berry is Professor of Clinical Surgery at the College of Physicians and Surgeons, Columbia University, and is now on leave of absence. He was appointed to this post in 1946. During World Wars I and II he served in the Army Medical Corps. Following the recent conflict he was promoted to the rank of Brigadier General in the Army Reserves. He is now on the retired list.

Dr. Berry was engaged in the practice of thoracic surgery in New York at the time he assumed his present duties in January, 1954.

As required by the Constitution and By-laws, this proposal will be referred to the Board of Censors for approval and then to the Society.

Nomination of Vice President of Washington Academy of Sciences: Dr. Frederick O. Coe has long represented the Society as Vice President of the Washington Academy of Sciences. The Board is pleased to nominate him to succeed himself in that office for another year.

Nomination of Members of the Board of Trustees of Medical Service of the District of Columbia: The terms of the following members of the Board of Trustees of Medical Service expire at the time of the annual meeting of the Service in April: Drs. Frank D. Costenbader, Henry L. Darner, and Maurice A. Selinger.

Your Board is pleased to recommend the nomination of Drs. Costenbader and Darner to succeed themselves for a three-year term, and Dr. Edgar M. McPeak to succeed Dr. Maurice A. Selinger for a similar period. Dr. Selinger has requested that he be relieved of his membership on the Service Board of Trustees, to which because of valuable service, your Board has reluctantly assented.

As is well known to many of our members, both Drs. Costenbader and Darner have given devoted and efficient service to the Society's prepayment plan. Dr. Costenbader was one of the architects of the plan and served as its first President. In the Board's opinion the Medical Service can ill afford to dispense with the services of either Dr. Costenbader or Dr. Darner. Dr. McPeak is well known to all of you and the Executive Board feels certain that as a member of the Service's Board of Trustees he will give a good account of himself.

Appointment of a Member of Board of Trustees of Group Hospitalization, Inc.: Early in January the Society was requested to appoint a member of the Board of Trustees of Group Hospitalization, Inc. for a term of five years to succeed Dr. Walter A. Bloedorn, who had been appointed by the GHI's Trustees to complete the unexpired term of Dr. Arthur C. Christie.

At its meeting on February 22 the Executive Board voted to submit for your approval the appointment of Dr. Richard H. Todd as Dr. Bloedorn's successor. As chairman of several Society committees, Dr. Todd has served with considerable distinction. Your Board is confident he will perform his duties as a member of GHI's Board of Trustees in a most satisfying manner.

Appointment of Delegates to United Community Services: For a number of years the Society has been represented in the councils of the United Community Services. Last year your Board appointed Dr. George Maksim, Chairman of the Society's Committee on Public Health, a delegate to the UCS' Board of Trustees. The Executive Board recommends Dr. Maksim's reappointment to this office for another year.

Annual Financial Report for 1953. [Space limitations will not permit the publication of the Report and the Budget. Members who are interested and could not attend the Business Meeting at which they were presented can obtain copies by calling the Society's office.]

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* Adopted at a special Business Meeting of the Medical Society of the District of Columbia, March 3, 1954.

Summary of Membership for 1953: . . . The Society continues to grow despite resignations, transfers, etc., which are continually taking place. Illustrative of this is the fact that at the close of 1951 the Society had a total membership of 1,777. This had increased by December 31, 1952 to 1,820 and at the close of 1953 to 1,910 members.

It may be of interest to you that in 1938 the Society had a total membership of 1,002. Five years later there had only been a slight increase, to 1,167; however, following the close of World War II the membership began to increase rapidly. In 1948 the total was 1,594 and by 1950 the membership had risen to 1,736.

Election of the Nominating Committee: Through an oversight the election of the Nominating Committee was not scheduled as one of the items to be included in this report. It is sufficient to state, however, that the following were elected members of the Committee: Dr. Robert H. Groh, *Chairman*; Drs. Victor R. Alfaro, Carl Berg, Daniel L. Borden, Robert J. Coffey, A. Magruder Macdonald, and William B. Walsh, *Secretary*. Dr. Groh, the Chairman, will shortly report to you for the Committee.

Conclusion: In concluding this report your Board wishes to remind you again that the Annual Business Meeting will be held on May 5. It is to be hoped that as many members as possible will be present for there is important business to be transacted.

An unusual feature of this meeting will be the opportunity afforded members who wish to do so to state their views with respect to the current medical issues which will undoubtedly be considered by the House of Delegates of the American Medical Association at San Francisco in June.

The Society is now represented by two delegates to the House who are most anxious to be responsive to the wishes of the membership. At a recent meeting of the Board they expressed the opinion that too many members were unfamiliar with the problems confronting the AMA's House of Delegates and the manner in which it deals with them. They suggested that at an early business meeting the membership be notified that both their questions and suggestions would be welcomed; that the delegates would be in a much better position to represent the Society adequately if they were fortified by points of view of the membership. Come to the Annual Business Meeting prepared to take part in this phase of the evening program.

Finally, the Board would suggest that you make a note of the coming FIRST INTERSTATE SCIENTIFIC ASSEMBLY to be sponsored jointly by our Society and the Medical Society of Virginia on November 1, 2 and 3 at the Hotel Shoreham.

Respectfully submitted,
WALTER FREEMAN, M.D., *Chairman*
WILLIAM M. BALLINGER, M.D.
HUGH H. HUSSEY, M.D.
PRESTON A. MCLENDON, M.D.
WILLIAM ROSS MORRIS, M.D.
HERBERT P. RAMSEY, M.D.
WALLACE M. YATER, M.D.
THEODORE WIPRUD, *Secretary*

NOMINATIONS

The following nominees for elective offices were presented by the Nominating Committee at the business session of the Medical Society of the District of Columbia on March 3, 1954:

For President-elect:
William Ross Morris

For First Vice President:
Paul R. Wilner

For Second Vice President:
Margaret M. Nicholson

For Member of Executive Board for 4 years:
Herbert P. Ramsey

For Member of Executive Board to fill the unexpired term of Dr. William M. Ballinger, resigned, 1 year:
R. Lomax Wells

For Member of Executive Board to succeed Dr. Morris, President-elect, 2 years:
Karl C. Corley

For Member of Board of Censors for 3 years:
James W. Watts

For Delegate to American Medical Association for 2 years:
Raymond T. Holden

For Alternate Delegate to AMA for 2 years:
Herbert S. Gates

Elections to the above offices will be held at the Annual Business Meeting of the Society, May 5, 1954.

On the Lighter Side

This is the story of an outstanding athlete who turned into a doctor specialist.

The year was 1915. Our man was young, strong and at his physical best at 188 pounds. He had entered college with great athletic promise, having been the elected captain of his preparatory school football team. Football was a natural for him, and his university took advantage of this skill for the four years of his scholastic life. Left end was his special forte and he was chosen in 1915 and 1916 to be one of the great All South Atlantic ends. In 1916 his name appeared on the honorable mention list for the All American Football Team, based on his achievement of being the highest scoring member of his university varsity football team. Ten years ago, he was named the outstanding left end on the All Time "Greats" of his university.

Football was in his blood. After graduation in 1918, and during the next three years of his medical school career, our man earned his keep and his tuition money by playing professional football for the Canton (Ohio) Bulldogs under the excellent coaching of the great Jim Thorpe. The games were played on week-ends, which meant riding the trains back and forth from Washington to the city in which the football game was to be played. There were no contracts in those days and each team member was paid at the completion of the game, providing the take at the gate was sufficient. The ordinary cuts and bruises resulting from the roughness of play, he patched himself as best he could from the day-by-day knowledge he obtained from his medical school classes. Those were rugged days for football and there was no elaborate medical set-up, as we know it today, to protect the players from injury, or to care for them if injury occurred.

During the summer months when football was in hibernation, our man worked as a camp instructor, and also as a lifeguard at Rockaway Beach in order to keep financially solvent until the next football season got under way.

Although football was his special talent, our man also played an exceptionally good game of baseball. He played the infield and the outfield with equal dexterity and batted fifth in the lineup. He was captain of his baseball team in 1917, when such opponents as Yale, Princeton, Dartmouth and the Army were on the schedule. However, he always went back to football when practice time rolled around.

No good athlete is satisfied with being a one- or two-sport man, therefore he became the light heavy-weight boxing champion in the intramural boxing program of his university in 1916 and 1917. The tenacity of his temper and the power of his punch were evident in the broken hand he sustained in one of his more rugged bouts. Even today, there are twinges of discomfort in that hand when the weather is wet and the wind is raw.

In 1954 our outstanding athlete who turned doctor specialist continues actively in sports. Two days each week during the cooler months he spends an hour on the handball court in active competition. On sunny weekends he is out on the golf course shooting in the 80's, or you will see him on the bucking back of his favorite horse riding after the hounds at the Redland and Potomac Hunt Clubs.

Besides his athletic prowess, he has other attainments. He is the proud father of five children, two girls and three boys. He has gathered unto himself many medical honors during his many busy years in the active practice of his chosen specialty, obstetrics-gynecology. Our man, the outstanding athlete who turned doctor specialist, is Dr. William (Bill) Cusack.

POTPOURRI: The Georgetown team of the D. C. Medical Bowling League has been without the able help of its captain, Dr. Roy G. Klepser, who has recently returned from Boston where he underwent surgery for detachment of the retina. The Bowling League and this column in particular wish him a speedy recovery and his return to the sport he loves so well. . . . Dr. Henry L. Darner presented a fascinating history-story of the Bermuda Islands recently at the University Club of Washington. Dr. Darner has made a hobby of the historical background of the 300 Islands and he illustrated his lecture with beautiful color slides.

J. Earl Kadan, M.D.

CHILDREN'S CONVALESCENT HOME

The Children's Convalescent Home provides convalescent care to children of the District of Columbia and adjacent areas. The Home was first organized in 1888, the property having been given by Charles Glover, then President of the Riggs National Bank, to a group of civic-minded women who felt that a place was needed for indigent mothers and their children for summer rest. These women formed the Board of Managers. The Home was then open only during summer months and was originally located on Broad Branch Road on the border of Rock Creek Park.

The original building was a low wooden frame structure with care and accommodations for about 40 children. The property itself, however, became so valuable, as that section of the District developed, that by 1929 the Board deemed it wise to sell and rebuild elsewhere. Concurrently, the demand for full-time care for convalescent children was developing, and it was decided to open the Home for all-year-round service to children under six. Many locations were visited before the present site was selected at 1731 Bunker Hill Road, Northeast. This piece of property was given by Mr. Arthur O'Brien. At that time in 1929 this area was definitely country, being about 10 miles out, at the edge of the District Line. Few houses then surrounded the site.

The Home, which is built along the lines of French architecture, was awarded a certificate in April, 1931 by the Board of Trade of the District of Columbia as the outstanding building in the District of Columbia for that year. Situated on a large wooded tract, the Home is completely equipped to handle all phases of exacting convalescent care and has facilities for 40 children. The Home, a Red Feather Agency, is maintained by the Board of Managers, and is a member of the United Community Services and the American Hospital Association. The constant aim of the Board of Managers is to provide a high standard of care in a physical and psychogenic environment, conducive to the enhancement of each child's physical and mental health, with all services of the Home geared to providing a well-rounded therapeutic program.

A rotating medical staff of 6 pediatricians and a psychiatric consultant, who is also a pediatrician, under the direction of Dr. Frederic G. Burke, the Medical Director, provides to all children a constant high standard of medical supervision. Additional medical supervision is provided by an affiliation with the pediatric teaching program at Georgetown University. Under this arrangement, 3 senior students are selected to reside and provide intern care for the children. This represents an elective course in the Georgetown University program. Credit is given to the clerks who are under the direct supervision of the attending pediatrician. Conferences are conducted in various phases of convalescent care by the staff for the benefit of these students and nurses. In addition, psychiatric integration and orientation classes are held to make convalescence, as soon as possible, a home away from home. With consideration of the reduced financial burden of convalescent care as opposed to general hospital care, significant advances have been noted under this program. The externs have provided significant liaison between the staff and the patients and serve in the capacity of providing continuous professional care. The professional staff includes a Director of Nursing Service, a medical social worker, a Director of Recreation and Volunteer Services, and 2 assistant recreation leaders. Graduate nurses, on duty at all times, are assisted by practical nurses and student nursery aides. The District of Columbia Health Department nutritionist provides consultant dietitian services. Volunteers assist the nursing and recreation staffs and have other duties, such as sewing and mending.

The Children's Convalescent Home is a generalized medical facility, as such children under care are recovering from a wide variety of medical, surgical, and emotional conditions. Their length of stay varies from a few weeks to several months, depending on their continued needs for convalescent care. Some of the underlying medical problems have been due to cerebral palsy, post-polio, heart disease, nephritis, chronic bronchitis, bronchiectasis, epilepsy, pneumonia, fractures, rickets, scurvy, marasmus, post-diarrhea, allergy, asthma, nutritional anemia, etc. In many cases their previous acute illness is complicated by a serious degree of nutritional anemia and emotional deprivation.

Eligibility for admission is based on the child's need for medical or psychiatric and nursing supervision. Residence is not a requirement as children are accepted from Washington, D. C., surrounding counties, and from hardship transient families. Charges are based on the family's ability to pay and the probable period of care required. The Home is equipped to furnish care to convalescent children from infancy to 6 years of age. Children under 5, with serious emotional problems, who require special care are accepted for periods of diagnostic study or treatment. No cases are admitted that have a communicable disease or have been in contact with a communicable or contagious disease which can be transmitted to other children in the Home.

Visiting Days: Parents and relatives may visit every day at any time and help feed, bathe and dress their children. Visiting is encouraged. Sunday is, of course, a big visiting day when all children look forward to seeing their parents and friends. Parents are requested to bring a favorite toy with their child when he is admitted to the Home.

Admission to the Home may be arranged by calling the Administrator's office (Lawrence 6-3600). All admissions require prior approval of the attending pediatrician. Application blanks are furnished on request and are made available to physicians, hospitals, clinics, and social agencies. The full cost of care during 1954 is $6.00 a day for private patients. Rates of payment for non-private cases are based on the family's ability to pay and the period of care required. Free care as well as part-pay and full-pay cases are accepted for care.

COMMITTEE TO STUDY LUNG CANCER IN DISTRICT OF COLUMBIA

The American Cancer Society estimates that lung cancer accounted for approximately 22,000 deaths in the United States in 1952. Further, it estimates that deaths from this site have increased five-fold since 1933. Based upon its own statistical studies and those of other organizations, the Society proposed at its Annual Meeting in November, 1953 that its Divisions meet in group sessions to develop: "A master plan to accomplish the early detection of lung cancer, centered around the specific objective of having all men over 45 have a lung X-ray twice a year."

Following the Society's Annual Meeting, staff members of the District of Columbia Division of ACS and physicians in Washington met to discuss the problem of lung cancer in the District of Columbia. After some discussion, the group decided that a study should be made of the extent of the problem locally before any specific program for lung cancer detection be proposed or undertaken.

Results of the study were presented at a meeting, February 27, of the Medical Committee of the Board of Trustees, D. C. Division of the American Cancer Society. Deaths from lung cancer in the District of Columbia increased 44.7 per cent in 1951 over 1950, according to the figures released at that meeting. A detailed analysis of 1952 cases has not yet been made.

The figures taken from the Tumor Register of the District of Columbia also indicate a 41.3 per cent increase of diagnosed cases of lung cancer in this same period.

Out of that meeting came a recommendation that in order to properly attack the problem of lung cancer detection a subcommittee of the Medical Committee should be established to work out a definite plan for the purpose.

The subcommittee, subsequently formed, was charged with:

1. Determining the extent of lung cancer in the Nation's Capital.
2. Evaluating the resources now available for chest X-rays and follow-up methods in the District of Columbia.

Those appointed to the committee are Dr. Frank S. Ashburn, *Chairman*, Chief of Chest Surgery at Providence Hospital; Dr. Robert J. Anderson, Chief of the Division of Chronic Disease and Tuberculosis, U. S. Public Health Service; Dr. Alfred A. J. Den, former head and Director of the Department of Radiology, Episcopal Hospital; Dr. Calvin T. Klopp, Director of the George Washington University Cancer Clinic; Dr. Forrest V. Schumacher, radiologist at Emergency Hospital; and Dr. Theodore Winship, Senior Attending Pathologist at Garfield Memorial Hospital.

Miss Wilma Dean Henry of the District of Columbia Division, American Cancer Society, will serve as the staff member of this committee.

NEW FEES AND POLICIES FOR PRIVATE NURSES

The Medical Society of the District of Columbia has been notified that on February 11 the Board of Directors of the Graduate Nurses' Association approved the recommendations of the Private Duty Nurses' Section on new fees and policies. The following schedule became effective on March 1, 1954:

1. Consecutive 8-hour schedule or fraction thereof	$15.00
Consecutive 12-hour schedule or fraction thereof	22.50
2. Hourly rates (to be used only when employment is specifically on hourly basis; total time not to exceed 3 hours)	
a. First hour or fraction thereof	4.00
b. Each successive hour or fraction thereof	2.00
c. When called for specific treatments (hypos, dressings, etc.)	4.00
3. Multiple nursing—nursing of two patients on emergency basis until another nurse is available	
8 hours, per patient	11.00
12 hours, per patient	16.50
4. TB—Polio—Mental and Alcoholic	
8-hour schedule	16.00
12-hour schedule	23.50
Multiple (two on emergency basis)	
8-hour schedule, per patient	12.00
12-hour schedule, per patient	17.00

5. Travel: Between hours of 12 midnight and 6 a.m. taxicab travel is at expense of patient.
6. Relief: May be requested for one day or more after 3 weeks' tour of duty with the same patient.

MEMBERSHIP

The following applicants for membership will be voted on at the meeting of the Executive Board, April 26, 1954.

For Active Membership

George A. Courie, Georgetown University—1949
James T. Fahey, Georgetown University—1949
Walter Lester Henry, Jr., Howard University—1941
John B. Johnson, Western Reserve University—1935
Richard J. Kemp, University of Maryland—1921
Marion E. Maclean, George Washington University—1949
William Newman, New York University—1946
George P. Petropoulos, University of Athens, Greece—1934
Lawrence V. Phillips, George Washington University—1952
Stacy L. Rollins, Jr., Jefferson Medical College—1944
Joseph W. Still, University of Nebraska—1936
Riley F. Thomas, Jr., University of Chicago—1932

For Associate Membership

Louis Burger, D.S.C., Temple University—1950
Martha Ray Lumpkin, Johns Hopkins University—1951
Guilford E. Naranjit, Howard University—1945

For Resident-Intern Membership

Robert N. Snider, University of Texas—1950
Edward S. Witowski, Jr., Georgetown University—1951

The following applicants for membership will be voted on at the meeting of the Executive Board, May 24, 1954.

For Active Membership

James Edward Boland, Georgetown University—1947
G. Bowditch Hunter, Jr., Johns Hopkins University—1950
Gerald Perman, University of Illinois—1949

For Associate Membership

Tatiana T. Antonovych, University of Vienna, Austria—1941
Henry G. Bullwinkel, Columbia University—1920
William Boyd Looney, Medical College of Virginia—1948

For Resident-Intern Membership

James K. Gordon, George Washington University—1952
Dean H. Martin, George Washington University—1950

News and Personals

MEETINGS—Past and Future

The Section on General Practice of the Medical Society of the District of Columbia and the District of Columbia Division of the American Cancer Society are sponsoring a series of 10 lectures on cancer detection and treatment for the general practitioners of the District of Columbia. Meetings are being held every Thursday at 8:30 p.m. with the purpose of making "every doctor's office a cancer detection center." This course was initiated at the request of members of the Section on General Practice so that they might learn to give a proper and thorough cancer detection examination.

The first five sessions, March 4 through April 1, were held at the Georgetown Medical School. Those attending the last five sessions, April 8 through May 6, are meeting at the new George Washington University Cancer Clinic.

Dr. Raymond T. Holden, Chairman of the Medical Committee of the D. C. Division, ACS, announces that the lectures have been approved for formal postgraduate study by the District of Columbia Chapter of the American Academy of General Practice. Topics which have been presented are: "General Problems of Cancer Detection and Treatment," Dr. Calvin T. Klopp; "Female Genital Tract," Dr. J. Keith Cromer; "Early Skin Lesions," Dr. Robert E. Moran; and "Intraoral Lesions," Dr. Robert R. Smith. The remaining lectures will consider cancer of the breast, thyroid, rectum, and lung, soft part tumors, lymphomas, and blood dyscrasias. All physicians in general practice are urged to attend these classes.

The District of Columbia Commissioners' Committee, in conjunction with the Spring Meeting of The President's Committee on Employment of the Physically Handicapped, is developing an **Exposition and Parade of Progress,** to be held on April 28, 29 and 30. The Main Lobby of the Departmental Auditorium on Constitution Avenue, between 12th and 14th Streets, N. W., will be used for displays known as Parade of Progress. A number of these exhibits will be static. Exhibits in Conference Rooms A, B and C will be known as Exposition. Handicapped persons will be present to demonstrate their ability to adapt themselves to work projects wherein they can best utilize their various skills.

The Exposition and Parade will be open to the public from noon to 5 p.m., and from 7 to 10 p.m. on Wednesday and Thursday, but only until 5 p.m. on Friday, April 30.

Mr. Edward Gale, Chairman of the Commissioners' Committee, presided at the meeting which was called on February 10 to draw up plans for the Exposition. **Dr. Milton Gusack,** one of the newer members of the Committee, was present. Representatives from a number of interested organizations were invited to attend this meeting. Representing the District Medical Society was **Dr. R. Lomax Wells,** Chairman of the Society's Committee on Industrial Medicine.

A public meeting on **Alcoholism—A Public Health Problem** will be held in the D. C. Medical Society's auditorium, Tuesday, May 18, at 8 p.m. Dr. Raymond G. McCarthy, Director of Alcoholism Research, New York Mental Health Commission, and a member of the faculty of Yale School of Alcohol Studies, will discuss "Problems in Rehabilitation of the Chronic Court Case Alcoholic." Mrs. Marty Mann, Executive Director of the National Committee on Alcoholism, will speak on "Emotional Immaturity of the Alcoholic Patient and the Goals of Rehabilitation."

The meeting is sponsored by the Alcoholic Rehabilitation Clinic of the D. C. Department of Public Health, in coöperation with the Washington Committee for Education on Alcoholism, the Subcommittee on Alcoholism of the D. C. Medical Society, and the Committee on Alcoholism of the Washington Psychiatric Society.

The Medical Library Association will convene in Washington, D. C., June 15–18, for its 53rd Annual Meeting. The headquarters will be the Hotel Statler, and the official host, the Armed Forces Medical Library. Complete information regarding the program may be obtained from Lt. Colonel Frank B. Rogers, Armed Forces Medical Library, 7th Street and Independence Avenue, S.W., Washington 25, D.C.

The District Mental Health Association is sponsoring a series of workshops on mental health for elementary school teachers, which are held on alternate Thursdays at 8 p.m., beginning March 4, in the Association's headquarters, 2227 M Street, N.W.

The first lecture in the series was given by **Dr. Seymour J. Rosenberg,** Secretary of the Washington Psychiatric Society.

The series will furnish an opportunity for teachers and officers of elementary schools to study the problems of emotionally disturbed children under trained psychiatric guidance.

Dr. Herbert P. Ramsey, President of the D. C. Medical Society, addressed the Public Health Committee of the Washington Board of Trade at the Burlington Hotel, February 25. He described "Health Programs of the Medical Society." Dr. J. Ross Veal, Chairman of the Committee, presided at the luncheon meeting.

The Women's Bar Association of the District of Columbia was host to the **Women's Medical Society** at the annual joint meeting of the two organizations. The dinner meeting was held at the Sulgrave Club, February 23. Chief Judge Bolitha J. Laws, the guest speaker, spoke in behalf of the family court as an innovation in court procedure for divorce and other domestic relations cases.

The George Washington University Medical Society held its regular meeting on March 17 in the Medical Society's building. Dr. Edward Weiss, Professor of Clinical Medicine, Temple University School of Medicine, addressed the Society on "Emotional Problems in Heart Disease."

GENERAL NEWS

The Executive Board of the Medical Society of the District of Columbia held its regular meeting on February 22. The Nominating Committee reported its slate of nominees to the Board, which is published in this issue of the MEDICAL ANNALS following the Interim Report of the Executive Board. Members of the Nominating Committee, selected by ballot by the Society, were: Dr. Robert H. Groh, *Chairman*; Drs. Victor R. Alfaro, Carl Berg, Daniel L. Borden, Robert J. Coffey, A. Magruder MacDonald, and William B. Walsh.

Dr. Richard H. Todd was nominated to the Board of Trustees of Group Hospitalization, Inc., for a 5-year term, subject to approval by the Society

Dr. Oscar B. Hunter, Jr., Secretary of the American Therapeutic Society, reminds members who wish to appear on the program of its 55th Annual Meeting in St. Louis, Mo., November 4–7, 1954, to submit the title of their papers, together with a 200-word abstract, in quadruplicate, to him as soon as possible. He also suggests that hotel reservations be made directly and immediately with the Chase Hotel. Tentative plans by the Program Committee call for symposiums on lipid metabolism and the newer drugs in therapy of hypertension.

The Council of the American Therapeutic Society has approved an arrangement with the American Geriatrics Society whereby papers presented at meetings of the former will be published regularly in *Geriatrics*, the official journal of the AGS.

The Joint Commission on Accreditation of Hospitals has just released its annual list of fully and provisionally accredited hospitals in the United States, its possessions, and in Canada. This list is the first published by the Joint Commission since it took over the actual hospital surveyal work from the American College of Surgeons, January 1, 1953. The Commission is supported by the American College of Physicians, the American College of Surgeons, the American Hospital Association, the American Medical Association, and the Canadian Medical Association. Headquarters of the Commission are at 660 North Rush Street, Chicago 11, Ill. Dr. Edwin L. Crosby, Director, has just been appointed Executive Director of the American Hospital Association.

Full accreditation was given to the following hospitals in the Washington Metropolitan Area: Central Dispensary and Emergency, Children's, Columbia Hospital for Women, District of Columbia General, Doctors, Eastern Dispensary and Casualty, Episcopal Eye, Ear, and Throat, Garfield Memorial, Georgetown University, George Washington University, National Homeopathic, Providence, and Sibley Memorial, all in the District of Columbia; Suburban, Prince Georges, Glenn Dale, Chestnut Lodge, Washington Sanitarium and Hospital, Maryland; and Alexandria and Arlington, in Virginia.

Dr. Francis M. Forster, Dean of Georgetown University School of Medicine, has announced 15 faculty promotions and 34 appointments to the faculty. Members of the District Medical Society who received promotions are:

Dr. Desmond S. O'Doherty, Assistant Professor of Neurology
Dr. Harvey J. Tompkins, Clinical Professor of Psychiatry
Dr. Anthony Zappala, Clinical Assistant Professor of Psychiatry
Dr. John D. Schultz, Associate Professor of Psychiatry
Drs. M. B. Pettit, Lucy D. Ozarin and Stanley Lester Olinick, Clinical Assistant Professors of Psychiatry
Dr. Earl B. Barnes, Associate Professor of Surgery
Dr. Herbert M. Giffin, Clinical Associate Professor of Surgery
Drs. Milton Goldman and George J. Fleury, Jr., Clinical Assistant Professors of Surgery

Members of the Medical Society who were listed among those newly appointed to the staff of the Medical School are:

Drs. Robert J. O'Donnell and W. Leonard Weyl, Clinical Instructors in Surgery
Dr. LeEarle B. Drake, Instructor in Surgery
Dr. Robert E. Byrne, Clinical Instructor in Urology
Dr. Henry R. Lyons, Assistant Professor of Psychiatry
Drs. Maxwell Boverman and Robert C. Burnham, Clinical Assistant Professors of Psychiatry
Dr. W. Proctor Harvey, Special Lecturer in Physiology

The 28th Annual Alumni Reunion of the George Washington University School of Medicine was observed, February 20. Conducted tours of the Hospital began at noon, followed by an alumni luncheon in the Hospital cafeteria. Seven members of the Medical School faculty presented lectures at the scientific meeting held in the afternoon. The topics presented and the lecturers were:

"Gynecologic Problems in Adolescent Girls," Dr. Barton W. Richwine, Associate in Obstetrics and Gynecology
"Studies in Lung Ischemia," Dr. Brian Blades, Professor of Surgery
"X-ray Diagnosis of Intestinal Obstruction," Dr. William W. Stanbro, Professor of Radiology
"Erythromycin in the Treatment of 190 Patients, Including 132 with Bacterial Pneumonia." Dr. Monroe J. Romansky, Associate Professor of Medicine
"Disability Evaluation," Dr. Charles S. Wise, Professor of Physical Medicine and Rehabilitation
"Management of Arteriosclerosis Obliterans," Dr. A. G. Prandoni, Associate in Medicine

The Annual Banquet was held in the Terrace Room of the Shoreham Hotel. The guest speaker, Senator Styles Bridges, of New Hampshire, discussed "Great Issues of Today."

The Society's annual award "for distinguished and meritorious service in the field of medicine or allied sciences" was presented to **Dr. Joseph H. Roe,** Professor of Biochemistry, for his "notable contributions in the fields of medical education, scientific research and public service." The presentation was made by **Dr. Luther H. Snyder,** President of the Society, before 340 members and guests. President Snyder emphasized the role played by Dr. Roe as a researcher in developing at least seven biochemical methods which are in common clinical usage today in diagnosing diseases.

Dr. Roe has been on the faculty of the Medical School since 1919. He became a full professor in 1922 and was head of the Biochemistry Department from 1922 to 1932, and again since 1938. He is one of 16 scientists to make up the Scientific Manpower Commission. During World War II he was a scientific consultant to the War Department on the selection of medical trainees, consultant to the committee on food composition of the National Research Council, and gas officer for the Washington Region of the Office of Civilian Defense.

The Jacobi Society held its annual banquet at the Hotel Statler, March 15. Dr. Irvin Hantman, President of the Society, presided. The principal address was given by the new Assistant Secretary of Defense for Health and Medical Affairs, Dr. Frank Brown Berry, on "Medical Defense Needs."

Certificates testifying that the recipients have completed 25 years' membership in the Jacobi Society were awarded by Dr. Jacob Kotz, one of the founders and first President of the Society, to Drs. Samuel Benjamin, Aubrey D. Fischer, Alec Horwitz, William C. Meiman, Aaron Nimetz, and Gilbert Ottenberg.

Dr. Everett J. Gordon was Chairman of the Committee on Arrangements for the banquet.

Dr. Darrell C. Crain, Clinical Assistant Professor of Medicine, Georgetown University School of Medicine, **and Dr. Thomas McP. Brown,** Professor of Medicine, George Washington University School of Medicine, were each presented a check of $3,000, February 11, for the **Arthritis Clinics** of their respective institutions by Mrs. Helen Parker, Secretary of the Board of Directors of the District Arthritis and Rheumatism Foundation.

Ground-breaking ceremonies for the new **Washington Clinic** took place on February 22, at 2 p.m., at the intersection of Western Avenue and Military Road. Dr. Joseph A. Bailey welcomed officials and guests who were present for the occasion. Following invocation by the Reverend Charles Kean of The Church of the Epiphany, some brief remarks were made by Dr. Paul C. Kiernan, who will be Medical Director, Senator Lister Hill, of Alabama, and Commissioner Renah F. Camalier. The first earth was turned by Senator Hill and Commissioner Camalier. Monsignor John Cartwright of St. Matthew's Cathedral gave the dedicatory prayer. Benediction was pronounced by the Reverend Kean.

Dr. Franklin M. Hanger, Professor of Medicine, Columbia University College of Physicians and Surgeons, who was in Washington in February as guest moderator for the Medical Society's Midwinter Seminar, delivered the **Smith-Reed-Russell Lecture** at the George Washington University School of Medicine, February 17. Following the lecture, Dr. Walter A. Bloedorn, Dean of the School of Medicine, gave a luncheon in honor of Dr. Hanger at the Army and Navy Club. Officers of the Society and members of the staff of the School of Medicine were guests at the luncheon.

A new **Multiple Sclerosis Diagnostic and Rehabilitation Center** at George Washington University Hospital was officially opened, February 15. Speakers at the ceremonies included Dr. Cloyd H. Marvin, President of the University; District Commissioner Renah F. Camalier; Mr. Marshall Hornblower, President of the District Chapter of the National Multiple Sclerosis Society; Dr. Pearce Bailey, Director of the National Institute of Neurological Diseases and Blindness; and Dr. Walter Freeman, Chief of Neurology at the Hospital. The new Center is being financed with a $5,000 grant from the District Chapter of the National Multiple Sclerosis Society.

At the Center each patient will be interviewed and examined by a team of physicians and other specialists who will recommend medicines, physical therapy, and other aids to the patients. No treatments will be provided the patients by the Center.

Persons interested in the new service may call the Hospital or the Society's headquarters at Decatur 2-2100.

A new **crippled children's clinic** was dedicated by the Kiwanis Club of Washington at 5551 Illinois Avenue, N.W., February 26. The Club has operated a children's clinic since 1921 and is now replacing its former quarters at Children's Hospital. Heading the officials present for the ceremony was District Commissioner Renah F. Camalier. Others present were C. Vernon Hill, President of the Kiwanis Club, and **Dr. Frank M. Hand,** Kiwanis Club member and supervisor of the clinic. Currently the clinic has 160 crippled children on its rolls.

The opening of a new infirmary at the Home for Aged and Infirm at Blue Plains marked a change in the name of the institution to **District of Columbia Village.** The infirmary, built at a cost of $2,800,000, was dedicated, February 28. A brick structure of concrete and steel, with bright tile walls and floors, it has a 344-bed capacity. Instead of the present 40 patients to a ward, no room will house more than 6 patients. Each of the infirmary's four floors will have ten 6-bed and eight 3-bed wards plus two private rooms. All the facilities of a hospital will be available with the exception of surgery. For the first time patients will have facilities for X-ray and rehabilitation. The older buildings will house ambulatory residents.

Dr. Jack Kleh, Medical Director of the new infirmary, will be assisted by **Dr. Timothy F. O'Donovan.** Both are Active members of the District Medical Society.

A free **psychiatric clinic** to serve 10 schools in the Northwest Section opened, March 1, at Macfarland Junior High School, Iowa Avenue and Varnum Street, N.W. **Dr. George W. Sprehn** serves as director of the clinic, assisted by a staff of three psychiatrists, two psychologists, two social workers, and two or three consultants. The staff serves one night a week free of charge.

The clinic will be open each Tuesday night during the remainder of the school year. The ten schools being served are, in addition to Macfarland, Health School, Roosevelt Senior High, Burdick Vocational, and Barnard, Raymond, Bancroft, Petworth, Powell, and West elementary schools.

PERSONALS

Dr. William P. Herbst was recently elected to membership on the American Board of Urology for a term of 9 years, from February 1954 until after the annual meeting in February, 1963. Dr. Herbst has served on the Board since May, 1953. At that time he was nominated by the American Urological Association, at its annual meeting in St. Louis, to represent the AUA on the Board.

Dr. Joseph F. Belair, Assistant Professor of Radiology, George Washington University School of Medicine, has been appointed Councilor for the District of Columbia by the American College of Radiology.

The Section on Radiology of the D. C. Medical Society elected Dr. Belair to represent it at the Eastern Conference of Radiologists for the next three years.

Dr. Murray M. Copeland, Professor of Oncology, Georgetown University School of Medicine, has been appointed to the Professional Education Committee of the American Cancer Society. He has also been elected Professional Delegate to Region II of the national organization by the District of Columbia Division of the American Cancer Society.

Lt. Colonel Lorenz E. Zimmerman, an Associate member of the District Medical Society, has succeeded Mrs. Helenor Campbell Wilder as Chief of the Section of Ophthalmic Pathology at the Armed Forces Institute of Pathology. Mrs. Wilder, who has gained international recognition as an ophthalmic pathologist, was recently married to Mr. Roland C. Foerster and resigned her position at the Institute, after more than 33 years' service, to go to her new home in San Francisco.

Dr. I. Phillips Frohman was elected to the Board of Directors of the District of Columbia Tuberculosis Association in February.

Dr. Herbert P. Ramsey, President of the District Medical Society, accepted the invitation of Dr. W. Montague Cobb, Editor of the *Bulletin of the Medico-Chirurgical Society, Inc.*, to appear on a broadcast, February 14, which publicized the coming meeting of the National Medical Association in Washington, D. C., August 9–13, 1954. Appearing with President Ramsey were members of the Board of Trustees of the NMA; Dr. Frederick Heath, Acting Director of the Public Health Department of the District of Columbia; and Dr. W. Palmer Dearing, Deputy Surgeon General of the Public Health Service.

Dr. Seymour Alpert, Associate Professor of Anesthesiology, George Washington University School of Medicine, was invited to address the Colegio de Cirujanos Dentistas de Puerto Rico during the annual convention of the Dental Society of Puerto Rico, in San Juan, January 28 to 30. His paper, given on January 29, was entitled, "General Anesthesia in Oral Surgery."

On his return home Dr. Alpert visited the Dominican Republic and toured the hospital in Ciudad Trujillo, the capital city, which has been named for Dr. William A. Morgan, Washington otolaryngologist, who for several years contributed his professional services to the people of that Republic during his so-called vacations.

Dr. Monroe J. Romansky, Associate Professor of Medicine, George Washington University School of Medicine, addressed the Regional Meeting of the American College of Physicians in Baltimore, January 16. He spoke on "Erythromycin in the Treatment of 132 Patients with Bacterial Pneumonia, as Well as Its Status in Other Infectious Diseases."

Dr. Romansky addressed the resident staff of Children's Hospital, January 26, on "Concepts on the Use of the New Antibiotics." At a meeting of the medical staff of Garfield Memorial Hospital, February 24, he presented a paper on "Indications for the Use of New Antibiotics."

Dr. Roland B. Scott, Chief Pediatrician at Freedmen's Hospital, was in Prairie View, Texas, March 1 to 4, where he served as guest lecturer for the 18th Annual Postgraduate Medical Assembly at Prairie View A. & M. College. In addition to conducting a clinic on pediatrics, Dr. Scott presented two papers, "The Diagnosis and Management of Allergic Disorders in Childhood" and "The Diagnosis and Treatment of Sickle Cell Anemia in Childhood."

The Postgraduate Medical Assembly is held annually under the auspices of the Texas State Department of Health and the Texas Tuberculosis Association.

Rear Admiral Lamont Pugh, Surgeon General of the Navy, accepted an invitation to address the senior class at Jefferson Medical College in Philadelphia, March 11. In an address entitled, "The Medico-Dental Team," Admiral Pugh stressed the importance of a close working relationship between the physician, the surgeon, and the dentist. He also discussed the opportunities and satisfactions from becoming a member of the Medical Department of the Navy.

President of the District Medical Society, **Dr. Herbert P. Ramsey,** addressed the Advance Gifts Group of the D. C. Chapter of the American Red Cross, February 23, prior to the opening of the national campaign for funds in March.

He also appeared on a television presentation over

CALENDAR OF SPEAKERS

The following members of the Medical Society of the District of Columbia have addressed lay groups during the past several weeks. The Society maintains a Speakers Bureau, sponsored by the Committee on Public Information, through which requests for speakers for lay groups, including radio programs, can be filled.

Date	*Speaker*	*Subject or Title*	*Organization*
February 10	Dr. Irvin Hantman	Causes and Treatment of Deafness	Lecture Series, YMCA
February 11	Dr. Zigmond M. Lebensohn	Psychology of the Sick and Handicapped	Public meeting sponsored by Volunteer Services Department, U.C.S.
March 1	Dr. Theodore C. C. Fong	The Community's Role in Caring for the Aged Mental Patients	Washington Armed Services Committee—Jewish Welfare Board
March 2	Dr. Henry P. Laughlin	Some Marry and Some Do Not	Good Neighbor Club, All Souls Unitarian Church
March 3	Dr. Edgar E. Quayle	A Salesman as a Medical Case	The Printers Supplymen's Guild of Washington, D. C.
March 14	Dr. Caroline Jackson	The Value of the Periodic Health Examination	Adult Education Class, Bethesda Baptist Church
March 16	Dr. Daniel Blain	World Health Organization and Mental Health	Men's Council, Gunton-Temple Presbyterian Church
March 16	Dr. Julius Schreiber	Living in a World of Tensions	Good Neighbor Club, All Souls Unitarian Church

WMAL the evening of February 23, which marked the public launching of the 1954 Red Cross fund-raising campaign.

Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, addressed the Conference of the National Committee on the Aging, part of the National Social Welfare Assembly, at the Willard Hotel, February 19. **Dr. Paul B. Cornely,** Professor of Preventive Medicine, Howard University School of Medicine, and other physicians participated in the Conference.

Dr. Murray M. Copeland, Professor of Oncology, Georgetown University School of Medicine, participated as an examiner for the Board of Orthopedic Surgery, Part II, in Chicago, January 21 and 22.

At the meetings of the James Ewing Society in New York City, March 12 and 13, Dr. Copeland was moderator for a panel discussion on diagnosis and treatment of cancer.

Dr. Andrew A. Marchetti, Professor of Obstetrics and Gynecology, Georgetown University School of Medicine, was one of the speakers at the Greensboro Academy Symposium of Medicine, March 25. The meeting was held at the Jefferson Club in Greensboro, North Carolina.

Dr. Gerald H. McAteer has been elected to the Board of Directors of the Merrick Boys Camp. **Dr. Joseph V. Kennedy** is the 1954 Camp President.

Mr. Ray H. Everett, Executive Secretary of the District Social Hygiene Society, will retire, April 30, after serving the Society for 21 years.

Mr. Everett has been a tireless worker in the field of social hygiene for 36 years, having been director of community organization and publications for the American Social Hygiene Association before coming to Washington. He graduated from Yale University's Law School and practiced law for a decade.

During World War I he was Associate Director of the War Department's Commission on Training Camp Activities. He was assigned by Secretary Newton D. Baker to study health and moral conditions in and near training centers, to prepare pamphlets, and to lecture to military personnel and key industrial groups on the hazards of venereal disease.

After the War, Mr. Everett and a small group of co-workers convinced John D. Rockefeller, Jr. that this public education should be continued, and large sums were contributed for the work. For 10 years Mr. Everett, as director of community organization and publications of the American Social Hygiene Association, edited the *Journal of Social Hygiene* and traveled throughout the country to organize state and local forces in combating commercialized prostitution and venereal diseases.

Coming to Washington in 1932, he organized a panel of volunteer lecturers with aid from the District Medical Society, the Medico-Chirurgical Society, and other professional groups to fight dangerous health and social conditions.

BOOK REVIEW

Steps Forward: Proceedings of the Fourth Mental Hospital Institute held under the auspices of the Mental Hospital Service of the American Psychiatric Association, Deshler-Wallick Hotel, Columbus, Ohio, October 20–23, 1952. Edited by Daniel Blain, M.D., Medical Director, A.P.A., with the staff of the A.P.A Mental Hospital Service. Paper bound. Pp. 242. Washington, D. C.: American Psychiatric Association, 1953.

One of the most commendable activities of the American Psychiatric Association in recent years has been its Mental Hospital Service. Since 1949 this Service has addressed itself to the numerous practical problems which confront the staffs of our mental hospitals in this country and Canada.

The present publication records the proceedings of the Fourth Mental Hospital Institute held in Columbus, Ohio, in October 1952. The sessions covered a wide range of subjects from Psychiatric Hospital Architecture to the use of the New Diagnostic Manual for Mental Disorders; from Training of Hospital Administrators to the Care of Patients' Clothing. These proceedings will be most useful to members of the psychiatric hospital staff. Reading this collection will reassure them that their problems are by no means unique and that their most troublesome problems are equally troublesome to the "experts." Numerous practical suggestions are made not only by the group leaders but by the members themselves.

These proceedings, like most reports of medical conferences, could stand even more editing. Even so, the report makes an important contribution to psychiatry's pressing problem, the improvement of the psychiatric hospital.

Zigmond M. Lebensohn, M.D.

CAT.

JOHN BENJAMIN NICHOLS, M.D.

(1867–1954)

JOHN B. NICHOLS, M.D.

Dr. John B. Nichols was born in Cazenovia, New York, February 2, 1867, and received his early education in the primary schools of his native town and at Cazenovia Seminary. He came to Washington, D. C., in July 1887. He enrolled in the Medical Department of Columbian College (now George Washington University) and received his degree in medicine from that institution in 1891, graduating at the head of his class.

Miss Anne Gledhill, of Oswego, Kansas, whom Dr. Nichols married on May 27, 1891, died in 1941. Howard Gledhill Nichols, their only child, was born in 1892.

From 1894 to 1899 Dr. Nichols was Assistant Surgeon at the U. S. Soldiers Home Hospital. After that he engaged in the active practice of medicine (internal medicine, laboratory diagnosis) until 1931. He served as pathologist at Garfield Memorial Hospital from 1900 to 1916, at Episcopal Hospital in the same capacity from 1901 to 1923, and as attending physician at Freedmen's Hospital from 1906 to 1919.

He was a member of the faculty of George Washington University School of Medicine as Instructor and Professor of Normal Histology from 1897 to 1908, and Lecturer in Dietetics from 1908 to 1919. He was Medical Inspector of the District Public Schools from 1903 to 1912, and a member of the Board of Medical Examiners of the District of Columbia from 1912 to 1915.

In 1902 Dr. Nichols became Medical Director of the Masonic Mutual Life Association, a small local fraternal insurance group, and in 1907 was elected to its Board of Directors. He was intimately associated with the growth and development of that organization, which later became the Acacia Mutual Life Insurance Company. In 1939, in recognition of his long and meritorious service, the Board of Directors of that institution made him Advisory Medical Director, a position he held until his death. His service to the company extended over a period of more than 52 years.

The services performed by Dr. Nichols in behalf of the Medical Society were many. During the years of his greatest activity no committee assignment was too small or insignificant not to claim his careful and assiduous attention; no task was too great for him not to sacrifice the time, effort and energy necessary to translate it into satisfactory accomplishment for the benefit of the Society.

He became a member of both antecedent medical societies, the Medical Association and the Medical Society, in 1898. Shortly his name began to appear as a contributor to the scientific programs in the presentation of many timely medical subjects. Likewise the records attest to many committee assignments in both organizations. In 1911 he was largely responsible for the welding of those two antecedent societies into one organization, our present Medical Society, of which he became the first President in 1912. He wrote the original constitution of the combined society, and later in the main authored the present constitution under which our society operates. He was chairman of the committee which arranged the Centennial Celebration of the Society in 1917, and for 12 consecutive years was a member of the Executive Committee. He also wrote Volume II of the "History of the Medical Society of the District of Columbia 1883–1944," an invaluable reference book which for him was a labor of love. In 1940 Dr. Nichols was awarded the Society's Certificate of Meritorious Service for having "served this Society in nearly every capacity for almost 50 years." In 1953 the Society established the John Benjamin Nichols Award of The Medical Society of the District of Columbia, which provides for the award annually of a certificate and medal to the lay organization or individual which has made the most outstanding contribution of the year to the health of the community.

Dr. Nichols' bibliography, encompassing nearly 90 titles, is too extensive for enumeration here. It comprises many articles in medical journals presenting personal and original observations and studies. A few are medical textbooks and cyclopedia articles. A group of papers relate to historical articles; some are based on genealogical research and other nonmedical subjects. In 1907 his essay on "Diet in Typhoid Fever" won the Fiske Fund Prize, and his literary work gained for him early recognition in "Who's Who in America."

He was a member of many other local and national societies and participated freely in their activities. Among these were the Clinical Society of Washington, the American Medical Association from 1905, the George Washington University Medical Society, of which he was President in 1910–11, the Medical History Club of Washington, the Washington Board of Trade, the National Genealogical Society of Washington, the Columbia Historical Society, and many others.

On the occasion of the fiftieth anniversary of the National Genealogical Society last year, Dr. Nichols wrote a comprehensive history of that Society from its inception and was named Honorary President in its anniversary year.

He became a member of Lafayette Lodge No. 19, F.A.A.M., in 1901 and became its Master in 1909. He was a member of the Cosmos Club since 1912.

Dr. Nichols' interests encompassed many activities outside his profession. He was an avid traveler, a keen observer of affairs and people, an industrious reader, student and philosopher. He possessed a fine mind and an equally fine sense of humor. He was in every sense a gentleman, a scholar, and a true physician. His death, which occurred at the home of his son, Mr. Nichols, at 4636 Hawthorne Lane, N.W., on February 22, 1954, at the age of 87, brought to a close a long career replete with the finest elements of service and accomplishment.

HARRY ZEHNER, M.D.

Radiotherapy in Cervical Cancer—Caulk

(*Continued from page 196*)

period. If this is true, it would of course explain the failure of improvement in the total statistics, because certainly the treatment technics were markedly improved over this period of time (1943–1947).

A preliminary survey of the 3-year survival rate, which includes the more recent material, would indicate that between 40 and 42 per cent of the patients that are accepted for treatment at this time can be expected to survive the 5-year period.

SUMMARY

A statistical evaluation of the results of radiotherapy in a large series of cases of cervical cancer treated in a general hospital has been presented. The figures are quite valid statistically, due to careful follow-up, with only 3 per cent of the material untraced.

It is more than likely that these figures are comparable to the results obtained elsewhere in a large number of cases of advanced disease.

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THE USE OF CHLORPROMAZINE IN THE TREATMENT OF ACUTE ALCOHOLISM[*][†]

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DELIRIUM tremens and psychomotor agitation are frequent complications of acute alcoholism, and their treatment at the present time consists for the most part of good symptomatic therapy. Perhaps the most difficult problem encountered in the management of such disturbances is the selection of an appropriate agent to control the manifestations of central nervous system excitation. Practically all available sedatives and central relaxants have been found to be either only partially effective, or to produce such intense depression that the patient is entirely dependent on the medical and nursing staffs to maintain his vital functions. Another objection to heavy sedation is that frequently on awakening the patient exhibits signs of excitation or release either from the alcohol ingested, or from the sedative prescribed, or from both. The ideal agent would be one that would relieve the patient of his excitation without causing too much depression or subsequent release, and which would permit him to help in his own management. The latter is particularly important in a hospital ward where many such patients are managed at one time.

Chlorpromazine has been used successfully in the management of disturbed psychiatric patients.[1] Sanguineti and Laricchia[2] and Sizaret and Salomon[3] have reported good results with the drug in 12 subjects with delirium tremens.

In this preliminary report we are presenting our experiences with this drug in 64 patients admitted to the alcoholic ward of the District of Columbia General Hospital, 21 with delirium tremens and the remainder with psychomotor agitation. In addition to the above disturbances, many presented complications commonly associated with chronic alcoholism, i.e., malnutrition, dehydration, avitaminosis, and cirrhosis. In order to evaluate the efficacy of the drug the usually prescribed adjuvants, such as vitamins, insulin and myanesin, as well as various sedatives and anticonvulsants, were withheld. The only immediate therapy consisted of fluids and chlorpromazine. The drug was given intravenously, intramuscularly, and orally.

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[*] This investigation was supported by a research grant (PHS B-178) from the National Institute of Neurological Diseases and Blindness of the National Institutes of Health, Public Health Service.

[†] Chlorpromazine (Thorazine) was generously supplied by Smith, Kline & French Laboratories, Philadelphia, Penna.

RESULTS

Effects of Intravenous Administration. In 16 patients chlorpromazine was given in doses of from 100 to 200 mg. intravenously in 250 to 500 c.c. of glucose in either water or saline. This solution was administered within a period of approximately 30 minutes, and after about 15 minutes from the time of the beginning of the intravenous administration, most patients were asleep. The first noticeable effect of the drug was tachycardia. Mental and muscular relaxation were next noted, and the patient would then drop off to sleep, usually before 100 mg. had been administered. Varying degrees of hypotension were observed but never to below critical levels with the patient in the horizontal position. The sleep pattern of these subjects could best be described as natural sleep; i.e., they could be aroused with very little stimulation, and on awakening, patients without delirium tremens were well oriented and coöperative. Sleep persisted for 3 to 5 hours, and during this period the patients could be awakened to eat, drink, or go to the bathroom, after which they would immediately go back to sleep. One patient became excited after being given 50 mg. but fell asleep after 100 mg. had been administered. When the effects of the drug wore off, it was either discontinued or again given either intravenously, intramuscularly, or orally, as indicated by the condition of the patient.

Effects of Intramuscular Administration. The difficulties attendant upon the administration of fluids in the disturbed patient are generally recognized, particularly when large numbers must be cared for at one time. Chlorpromazine may be given intramuscularly, but because of its irritant effect it must be injected into deep muscle tissue. To date we have treated 28 patients with chlorpromazine given intramuscularly in doses from 100 to 150 mg. In some of these patients the injection was repeated within 6 to 8 hours when required. Except for the delay in onset of action (approximately 1 hour), the effects of the drug intramuscularly are essentially similar to those following intravenous administration. Acute hypotension has not been encountered in patients given the drug intramuscularly. Once the patients are asleep, intravenous fluids may be administered without the usual difficulties. At the present time we have discontinued the intravenous use of chlorpromazine because of the satisfactory results obtained by its intramuscular and oral administration and because fluids may be ingested in adequate amounts while under the influence of the drug.

Effects of Oral Administration. The drug has been given orally to practically all patients in this study in doses of from 100 to 200 mg. Oral administration has been resorted to when the patients showed only a moderate degree of excitation on admission or following intravenous or intramuscular medication. When given orally, approximately 60 to 75 minutes are required for the drug to become effective. Acute hypotension has not been noted following oral administration.

DISCUSSION

Many of our patients were chronic alcoholics, and their reaction to the drug may be of interest, since most of them have previously received either barbiturates, paraldehyde, or both. The impressions of the patients were very favorable, and probably most important was the comment that "you are not nervous after you come out of it the way you are with paraldehyde."

It is our present opinion that the time required to overcome the excitatory state is neither shortened nor prolonged by chlorpromazine. The course of therapy required varied from 1 to 4 days. In no instance was there intense central nervous system depression attendant with its use, nor was there any evidence of synergism with the alcohol that may have been present. There were no fatalities in the present series of cases.

Chlorpromazine is recognized as a potent antiemetic, a property that appears to have considerable value in the management of subjects with acute alcoholism. Many of our patients complained of vomiting prior to admission, but in only 1 patient was vomiting associated with the use of chlorpromazine. As previously indicated, all other subjects had no difficulty in retaining food or fluids.

Convulsions are frequently observed in patients with acute alcoholism, and it may be significant that convulsions did not occur in the present series of cases.* Courvoisier[4] has reported that chlorpromazine has mild anticonvulsant properties.

As previously indicated, the mean arterial pressure may occasionally fall following the intravenous administration of the drug. As long as the patients are maintained in a horizontal position the hypotensive action of the drug should not be any cause for concern if given as outlined above. Orthostatic hypotension with syncope has been encountered on 2 occasions when the patients either sat up or were ambulatory. The blood pressure returned to normal when the patient was placed in the horizontal position.

Chlorpromazine is reported to act synergistically with aliphatic narcotics.[4] We have not found it necessary in this series of patients to use either paraldehyde or barbiturates in conjunction with chlorpromazine. If one desires to use combinations of drugs, it would be advisable to reduce significantly the dose if either barbiturates or paraldehyde are given along with the chlorpromazine.

Much work has been done on the pharmacologic properties of chlorpromazine; however, there is little information regarding its mechanism of action on the central nervous system. The evidence to date would suggest that chlorpromazine may have a blocking effect on the diencephalon. Its multiplicity of actions, the induction of sleep, hypothermia, hypotension, and its antiemetic effect all suggest hypothalamic action.

SUMMARY

Chlorpromazine has been used in the management of over 64 subjects with acute alcoholism, 21 with delirium tremens and the remainder with psychomotor agitation. It was found to be highly effective in controlling the acute mental and physical aberrations associated with these states, the drug inducing a sleeplike state from which the patient could be easily aroused to take required nourishment and fluids. The time required to recover from the excitatory phase does not seem to be influenced by the drug; however, it appears that it possesses definite advantages over the sedatives usually employed.

N.B. We wish to thank the members of the medical and nursing staff of the Psychiatric Department, District of Columbia General Hospital, for their fine coöperation in this study.

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* Since this report we have seen convulsions in 3 patients receiving chlorpromazine.

WHY DO WE GIVE SO MANY DRUGS?*

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"The time has come, " the Walrus said,
"To talk of many things:
Of shoes—and ships—and sealing wax—
Of cabbages—and kings."

WITH these familiar words, you will remember, Lewis Carroll begins the denouement of the story of the Walrus and the Carpenter. The same words remind us that the time has come for us physicians to talk to each other about some of the things we often overlook. Prominent among these is the excessive use of drugs.

Why do we use so many drugs when so few are necessary? Is it lack of knowledge, or carelessness? Is it willful disregard of the rules of safety, or inability to keep abreast of the flood of new remedies? The answer is not easily obtained. Our plight needs the help of a diagnostician who is an expert in the field. After prolonged search, I called upon one of the pioneers of modern science, one who made a study of false ideas and how they keep men from seeing and doing what is right, Sir Francis Bacon. In his *Novum Organon* he wrote of four kinds of false notions, or idols as he called them, which beset the human mind. These are the Idols of the Tribe, the Idols of the Cave, the Idols of the Market Place, and the Idols of the Theatre. Perhaps a scrutiny of these idols three and a half centuries later might assist us in discovering and uprooting the false notions of today which relate to the misuse of drugs. Perhaps we may find that we, too, have idols of the tribe, of the cave, of the market-place, and of the theatre.

The idols of the tribe may be likened to the false notions which patients have acquired as a result of hearing by radio or word of mouth, or of reading the reams of printed matter which purport to tell of medicine's "great discoveries." Inasmuch as vitamins and endocrines, the sulfa drugs and antibiotics have brought about so many dramatic cures, the physician must be either lazy, heartless, or ignorant who fails to employ one of these drugs for every illness. So think those who worship the idols of the tribe, and it seems that most people do today.

Listen to Dr. J. B. Herrick,[1] whom you will recall as the first person to describe the clinical syndrome associated with myocardial infarction, as he tells in his autobiography, "Memories of Eighty Years," of an incident which occurred more than half a century ago:

> "About 1895 or 1896 my experience with my first case of diphtheria treated with diphtheria antitoxin made me a firm believer in the specific nature of that form of treatment. When, therefore, Dan White, the neighborhood lamplighter—the street lamps were lighted by gas in those days—called me to see his child who had a frank diphtheria, I announced that antitoxin must be given. Dan protested that I had treated his family before and my medicine was 'every damn bit as good as this new-fangled stuff.' When I answered him that I had tried it —though not telling him my experience was with only one case—he wanted to know the result. I assured him it was favorable. Had I seen the report of the death of the Brooklyn doctor's child? said Dan. Yes, I had, but that made no difference. The remedy was to be used here, or he would have to get another doctor. Finally, 'Well, go ahead, but I'll blow the roof off the shanty if things don't go right.' Well, things went right. I gave the sick lad his dose. Dan thought I was rubbing it in when I gave prophylactic doses to him, his wife, and the other children. Within forty-eight hours the father was radiant. 'Mike, the young spalpeen, is sittin' up in bed hollering for something to eat, while young Dan, who's a skeleton and who has been sick two weeks and under Dr. ——, is cross-eyed and can't swallow right; the water comes back

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* Read before the George Washington University Medical Society in Washington, D. C., November 18, 1953.

through his nose!' . . . I never had a better advertising agent than Dan White, who sang my praises and who told with great gusto how he had 'very nearly kicked Doc Herrick out of the house, I was that mad.' "

How this resistance against a new therapeutic agent contrasts with the voracious hunger for the newest remedy which propels our patients to our consultation rooms clutching in their eager grasp a clipping from *Clock Magazine* or the *Daily Ink-waste* which extols the wonders of Dr. Labshelf's discovery for Arterial Innercoatitis! What chance does the lone doctor have against this flood of printer's ink!

But let us pause a moment. In considering at such length the idols of the tribe, we may be attempting to pull the motes out of our brothers' eyes without first removing the beams from our own. Our consultant, however, does not allow this to happen. He warns of the idols of the cave, by which he means the errors which are peculiar to each individual.

The idols of the cave are the beams in the doctor's own eyes. In his zeal to do all he can for his patient the physician sometimes fails to see clearly what will and what will not help. The doctor is but human. When he sees his patient in distress and pain, his own emotions are aroused or, in the words of the psychiatrists, he identifies with the patient. His emotions push him into doing something, and this usually means giving a drug. Thus the words, "It won't hurt to try a shot of Miracle-mycin" often become the prelude to a debacle.

As for the idols of the market-place, these are paraded before us in the advertisements of medical journals, in the postman's daily offering, and in the sleight-of-hand which the representative of the pharmaceutical company performs upon the doctor's desk. How the hucksters of Bacon's day would have reveled in the trimmings and trappings of the multimillion-dollar industry of today! How much harder it is to recognize idols for what they are when they are described in ink of many colors and are wrapped up like Christmas presents.

What Bacon calls the idols of the theatre we would recognize better if entitled the idols of the lecture hall. They are "idols which have crept into men's minds from the various dogmas of peculiar systems of philosophy, and also from the perverted rules of demonstration." The idols of the lecture hall deceive us more insidiously than any of the others. A man worships nothing more intensely than a theory which he believes he has originated himself. The pride of ownership drives him to preach about his apparent discovery to all who would listen. Like the Ancient Mariner "he stoppeth one of three" and "holds him with his glittering eye" while he unfolds his tale. Long before properly controlled observations have been made, he has convinced a band of disciples. Fortunately, as Lincoln said, "You can't fool all of the people all of the time." Man's powers of reasoning usually come to his aid, careful observations are made, and the vaunted remedy is thereafter employed only where it will do some good, or, if there are no such cases, it sinks quietly into oblivion.

Some physicians have decided that since the prior use of penicillin will prevent a few, selected infections, therefore all infections can be prevented by the prior use of antibiotics; likewise, since most pneumonias can be cured by penicillin, therefore penicillin should be given during every respiratory infection to prevent the onset of pneumonia. Bacon says again, "The human understanding, from its peculiar nature, easily supposes a greater degree of order and equality in things than it really finds; and although many things in nature be . . . most irregular, will yet invent parallels and conjugates and relatives, where no such thing is."

If these be false idols and we must needs sweep them away, what should we put in their places? There is a direct and sensible approach to treatment which is as sound as it is simple. First, a diagnosis or a tentative diagnosis should be made. By this I do not mean that the unfortunate patient must be subjected to every laboratory test which ingenuity can devise. Rather, I am suggesting that a history elicited by well-chosen questions and an examination which depends upon the use of the five senses, sometimes aided by a few selected laboratory tests, will lead the physician to a sensible conclusion. I believe sincerely that for a few minutes the physician should focus the strong white light of reason upon the problem at hand, that he should marshal the pros and cons of each possible cause for the patient's illness, until he arrives at the best possible tentative diagnosis. By fulfilling this duty to himself, he will have fulfilled his duty to the patient.

As Polonius said to Laertes:

> "This above all: to thine own self be true,
> And it must follow, as the night the day,
> Thou canst not then be false to any man."

Second, the physician would do better to know a few drugs thoroughly and to be able to use each skillfully as the occasion arises, than to flirt with each new remedy as it comes along and to know none well. Most new drugs are only a slight modification of those which already exist. The rare one which is truly revolutionary gets a prompt trial and a ready report. In these days when the radio and television compete persistently with the printing press for our attention, we need not fear being left in the dark. Rather we must fear the conflicting lights and shadows which result from the beckoning torches of those who would deceive us and the will-o'-the-wisps with which we confuse ourselves.

Third, it is often the better part of wisdom to explain instead of prescribing. True, explanations take extra minutes, but they invariably save extra hours. Every physician is a teacher. If he does not take the time to teach in words, he is teaching, by this very neglect, that he considers the subject at hand to be unimportant. The invariable bottle of medicine from the doctor debases the physician's calling by leading the patient to believe that the doctor is fit for nothing else. Then too, if the remedy prescribed in such an off-hand manner does not produce the desired effect the patient is more frightened and disheartened than before, for now he has lost faith in his doctor. An explanation, instead of a pill, would not have raised his hopes to a pinnacle and then dashed them to the ground.

The fourth suggestion is advanced in all humility to those who direct the pharmaceutical industry. In the long run, a drug can be sold only on its merits. The advancement of the industry will come about through the discovery and production of worthwhile drugs and the prompt abandonment of those which are inferior or harmful. The reckless and excessive use of any drug cannot help but redound to the discredit of the drug itself and of the industry as a whole. For such misuse will be followed by failures and untoward reactions until physician and patient alike will recoil in disgust; and the more highly its virtues had previously been touted abroad the more debased its eventual reputation, for thus passes the glory of the advertising world.

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THE USE OF CARBON DIOXIDE IN TREATMENT OF NEUROSES

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BENJAMIN RUSH (1799) well defined the pathologic mental state by saying that the healthy reactions of the body in the waking state are made of what is called "excitability" and "excitement"; that health consists in their exact proportion and a due relation of both diffused uniformly throughout every part of the body. Today we call this homeostasis. Therefore, disease, the reverse of this, Rush[1] stated, depends in large part upon a disproportion between these two and in a partial distribution of each of them.

Today we regard psychoneurotic aspects of behavior as being symbolic. Since, as emphasized by Meduna,[2] the real meaning of symbolic manifestations is assumed to be hidden from the patient in what we term the "subconscious," only by desymbolizing the psychoneurotic symptoms can we do away with the underlying trends and desires that disturb the patient and affect his behavior.

Psychoanalysis has revealed that a symbolic pathologic symptom rarely is the expression of some single disturbance, but, rather, represents some other symbol which in turn expresses still other symbols lying even deeper. It is because of these underlying emotional disturbances that the neurotic tendencies of an individual are so difficult to interpret.

Any procedure, therefore, that can influence the emotional trends of the patient may successfully influence his neurotic behavior.[2]

Production of a psychoneurotic condition depends upon the ratio between the degree of disturbance of the homeostatic balance and one's ability to restore this equilibrium. When there is a disproportion between excitement and excitability the individual develops a low threshold to some subnormal stimulation or may react unduly to a normal stimulation. The suffering which follows will be greater in that individual than in a normal person. Therefore, reëstablishment of a homeostatic balance will be delayed, inhibited, or even prevented.[3, 4]

If we accept this explanation, we can concede that a procedure which succeeds in increasing the threshold of stimulation of the brain will facilitate reëstablishment of the homeostatic balance and ultimately bring about a change in behavior. A recent procedure which apparently succeeds in increasing the threshold of stimulation of the brain of the psychoneurotic patient is the utilization of carbon dioxide.

The use of carbon dioxide in the treatment of mental illnesses, first advocated by Meduna in 1947, has received new impetus from the recently reported successes of a number of experimenters who have reported use of this method in a total of over 1,000 cases. I[5] stated earlier that the method was not generally accepted and that further research and observation are indicated. It is still too early to determine the permanency of the improvement or cure, but a sufficient number of cases has been reported in which a high percentage of the patients followed up for almost 2 years have shown continued improvement, and I determined to undertake a study of this therapeutic procedure myself. My cases are still too few in number and have been treated for too short a period to determine the full efficacy of the treatment. However, I believe sufficiently in the method to advocate its trial and herein submit a short review of the published studies.

When Loevenhart, Lorenz and Waters[6] attempted treatment of psychotic patients with CO_2 they noted that catatonic patients given a 30 to 40 per cent carbon dioxide in oxygen mixture responded with mental clarity for short periods, but the treatments were given up as of no permanent value. It is still acknowledged that the psychoses do not respond to this therapy. Meduna,[2] on the theory that the lesser mental illnesses can be ameliorated or cured by a change in metabolism, attempted carbon dioxide treatment of psychoneurosis and reported his success in 1947. He explained the recoveries which followed this treatment on the basis of physiologic-biologic changes. A number of others soon reported similar results.

The neurotic patient who is accepted for this treatment is told that his illness is apparently one of the nervous system and that after he inhales a gas, a perfectly safe procedure, he probably will have unusual dreams with or without emotional episodes, or he may have an emotional upset without dreams. He is encouraged to recall these sensations upon awakening. He is told that he may feel much better after the treatment.

Usually treatments are given 3 times a week. After the treatment, which takes about 6 minutes, the patient can leave immediately, unassisted. A total of from 20 to 150 treatments may be required for a cure, but, if the patient does not show improvement after 20 to 30 treatments, there is little use of continuing the course. Meduna and Jackman[7] find that the average patient requires only 20 to 30 treatments for full recovery.

In some patients improvement follows abreaction of his pathogenic emotions, that is, living through the emotional experience again. These reactions may be quite dramatic, the patient, as he relives the pathogenic experiences, discharging his pent-up emotions with great force. In others the abreactions may occur in dreams unrelated to reality, but subject to psychiatric interpretation. Some patients exhibit no emotional discharge, while others who show no emotion at the time may later in the day recall forgotten or suppressed pathologic experiences and are able to relate these experiences to their disturbing symptoms.[3, 4] With continued treatments, more and more of these old experiences are revived and the pathogenic symptoms correspondingly disappear.

The patient lies comfortably on a bed or treatment table and receives a 30 per cent carbon dioxide and 70 per cent oxygen mixture in 20 to 25 respirations; an additional 3 to 5 respirations may be required to produce unconsciousness. Occasionally a patient will lose consciousness at the third or fourth respiration, suggesting a latent epileptic disposition.[8, 9] An anxious patient may pant and therefore require 60 to 100 shallow respirations before losing consciousness. Fear may develop, the anxiety neuroses present increasing to panic after 15 to 20 treatments, possibly because too many respirations have been given at a single visit; or fear may develop, not of the treatment, but of again experiencing the horrifying dreams.

To obviate this fear in anxiety cases, Meduna administers nitrous oxide first to relieve the patient's anxiety, then the CO_2-O_2 mixture, and finally before removing the mask, nitrous oxide again for 10 to 15 seconds. This makes the patient forget the dreams and softens the emotional impact of the experience.

A patient who awakens from the anesthesia irritable, tense or frightened, and does not calm down in a few minutes may at once be given a second treatment of 20 respirations of the carbon dioxide with or without nitrous oxide.

This preliminary anesthesia with nitrous oxide is also advocated by Silver, since it makes it easier for the patient to breathe. I use this method routinely.

When nitrous oxide is not used, the patient is urged to count his respirations aloud and on regaining consciousness to tell the last number he remembers. At the next treatment he is given 3 or 4 more respirations than that number to insure unconsciousness. Counting is impossible when the nitrous oxide is given, because the patient is unconscious when the CO_2 is administered. Unconsciousness is then determined when slight quivering of the fingertips occurs, followed soon by marked rigidity of the limbs. The breathing is then mechanical.

Usually about 48 inhalations are required for a convulsive reaction. Four patients carried to the convulsive stage by Jackman[8, 9] required an average of 62 inhalations; occasionally he found it necessary to go as high as 98 inhalations. It is a perfectly safe procedure, and care of the patient is simple if the bed is against the wall, so that the patient does not fall out. No fractures have occurred. The shock is never so severe as that received from Metrazol or electro-convulsive therapy.[8, 9] Not all experimenters have found unconsciousness necessary. Milligan[10] gives initially a mixture of 10 to 15 per cent CO_2, increases it after 20 to 30 respirations, then returns immediately to the lower dosage until 25 to 40 respirations are recorded. The patient then experiences the old emotional experience. Wilkinson,[11] who treated 250 cases, substitutes the word "subcoma" for "subconsciousness" and notes that the patient after 12 to 20 respirations has a marked response on the part of the sympathetic nervous system, but if the treatment is continued to coma, there is a parasympathetic response. Since depressed patients have a preponderance of parasympathetic symptoms, he prefers to discontinue the therapy at the level of sympathetic response, just before the patients lose consciousness. Patients with psychoneurotic symptoms without depression, however, either fail to benefit from subcoma treatment or are made worse. They therefore require the unconscious state.

Patients receiving coma treatment without production of the convulsive state, Wilkinson[11] found, often react dramatically. Although some show violent muscular activity, some scream for a considerable time, others have fits of laughter, and some cry and laugh alternately or at the same time. It is thought that these reactions serve as a catharsis.

The physiologic effect of the CO_2 treatment, according to Meduna, is: (1) an increase of the membrane potential of the nerve, accompanied by a rise of the threshold of stimulation of the nerve, (2) an increase of the height of the action-potential, prolonging its duration, (3) an increase of the height and duration of the negative after-potential, and (4) decrease of fatigability of the nerve cell. Fatigability, being delayed, the ability of the nerve to conduct trains of impulse is increased.

As the membranous potential increases, there is an accompanying increase in the threshold of stimulation with respect to inner and outer stimuli. This influence on the structural organization of the psychoneurotic syndrome, Meduna[3] says, can be understood when we think of the nervous system as having an inherent tendency to restore its previous balance, or to achieve a new balance after the stimulus which has upset it ceases.

Freeman[12] explains that within the central nervous system are closed loops of nerve cells continually exciting one another. Stimuli received by these circuits continue to reverberate with reference to the initial stimulus. The impulses are retained within the brain, independent of any neutral system. A sense impression once registered is retained by the neuronal loop. Successive ideas are awakened as each loop of nerve cells begins to reverberate. These closed circuits are believed to contain all the data appertaining to memory, concept, and phantasy formation.

How these neural nets become the seat of mental deviations is postulated by McCullough.[13] He notes that efficient and harmonious activity of the neural pathways depends on the relationship existing between the various impulses circulating within the network. Any increase in the input correspondingly increases the output of nervous impulses and thus restores the equilibrium.

Any alteration occurring in the neural connections (at the synapses) upsets this regulating mechanism. Instead of incoming impulses being diminished, they are increased. Therefore, if these neuronal nets are basic in mental life, any disturbance in their function can produce a neurosis, a psychosis, or some other psychologic abnormality.[12]

As McCullough[13] expresses it, the "unconscious" is "nothing but the suppression of information; the memories and the learned reactions subserved by circuits connected with the regenerated circuit can no longer be evoked, not because anything has happened to them, but simply because all the stimuli which once evoked them, feeding secondarily into the regenerative circuit, now produce only the invariable neurotic response which displaces all the others. In effect, such memories and such learning become inaccessible although they return as soon as the circuit ceases to regenerate." This process produces an active repression.

A psychoneurosis, therefore, may be considered as a continuous circulation of nervous impulses "no longer in step with the rest of the brain. A rational approach to the disorder is to increase the threshold of stimulation of neuroses so that they are no longer stimulated by the abnormal process. An initial isolation of the disturbed circuit is followed by a restoration of equilibrium throughout the nervous system."[13]

Meduna suggests that the effects of the CO_2 anesthesia endure long enough to give the entire brain sufficient time to provide an increased threshold for inside stimuli, and for the normal homeostatic balance of the brain to begin to function. After repeated inhalations over a protracted period of time, the patient achieves this normal homestatic balance, and his excitability to old and new pathogenic influences then becomes so lowered that they no longer exercise a pathogenic influence.[12]

Freeman[12] objects that these hypotheses are one-sided. He thinks that, although good results are shown to follow the CO_2 treatments, relapses can be expected because the psychologic influences are overlooked. Therapeutic methods necessarily must take into consideration the unconscious dynamic forces which are set free by the technic of this procedure. Psychiatric therapy should properly follow the CO_2 treatments. Since this is admittedly true, I suggest that this is one reason for the limited effect of the treatments in some individuals.

Whatever the physiologic or psychologic basis of the effectiveness of the treatment, it must be acknowledged that good results have been obtained.

Moriarty[14] in 1952 reported a series of 66 cases, with 39 per cent much improved, 43 per cent improved, 18 per cent unimproved. In Meduna's and Jackman's last reports[3,15] (1953) Meduna had treated 520 patients with a recovery rate of 62 per cent; Jackman treated 204 patients with recovery in 68 per cent and 10 per cent more showing clinical improvement.

Other reported cases in 1953 were those of Silver, Wilkinson and Smith. Silver,[16] in a follow-up of 69 of 100 patients in his first group after a 12- to 20-months' period, found effective results sustained in 45 per cent; in 72 of the second group of 100 followed after 6 to 12 months, about the same percentage of improvement was noted. Some patients whose condition was recognized as practically hopeless at the start were given treatments anyhow, since the treatment is harmless.

Wilkinson[11] administered the treatment to 200 patients but does not report the percentage of cures. Smith[17] treated 33 patients with not a great deal of success; in 33 only 4 responded quickly and sustained their improvement; 8 had slight improvement over a period of 6 to 8 weeks; the remainder showed no improvement. These patients were followed for 6 months to 2 years.

It is generally agreed that psychotic patients do not respond to this treatment. Also, not all psychoneurotic patients show improvement following treatment with CO_2. Patients with obsessive-compulsive neuroses show little if any benefit, but Jackman[8,9] suggests that improvement may result if treatments are continued for a year. These cases respond best to electric-shock therapy.[17] Mild depressive cases, uncomplicated anxiety cases, some stutterers, and cases in which "tension" is an important factor have been cured or greatly improved after a course of treatments. Jackman found improvement in 2

(*Continued on page 302*)

PLACENTAL MANAGEMENT IN ABDOMINAL PREGNANCY

Review of the Literature and Report of a Case

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ABDOMINAL pregnancy is a rare form of ectopic pregnancy which may occur as a primary implantation but usually occurs secondary to rupture, abortion, or growth from a tubal pregnancy and, rarely, from an ovarian pregnancy. In abdominal pregnancies at term a retrospective history suggesting early tubal pregnancy is almost always obtained. The rupture may occur into the broad ligament and development take place in that location.[1, 2] The growth of the fetus may continue in the tube, resulting in tubal pregnancies at term, occasionally with a living child.[3] What the authors[3] believe to be the sixth case of tubal pregnancy at term in which both mother and infant survived has recently been recorded. Five examples of combined full-term intra- and extra-uterine pregnancies have been found in the recent literature. Up to 1948, 395 cases of authenticated combined pregnancies had been recorded. In only 14 of these were both children born or extracted alive.[4] Most of these unusual cases have occurred in South Africa.[4-8] Repeated term abdominal pregnancies in the same women have also occurred very rarely.[9]

Incidence

It is impossible to cite the exact incidence of abdominal pregnancy at term. This varies considerably with different areas and population groups. It was found to be 16 times more common in Negresses in the Baltimore area.[10] MacGregor[11] reported the incidence as 1:6,646 obstetric and gynecologic admissions and found the greatest number in women over 24 years of age. Lee in a 5-year survey found 1 secondary abdominal pregnancy in 9,999 pregnancies, while Douglas in discussing Ware's report[12] gives the incidence as 26 cases in 425,620 live births, or 1:16,370. Others[13] give the incidence as 1:2,207 deliveries.

Diagnosis

The key to proper diagnosis of this rare condition is the physician's awareness of its possibility. Once the thought of abdominal pregnancy is entertained the physician will seldom fail to make the diagnosis. As in the case presented, it was not until the patient's husband remarked, "Doc, there's something very wrong with this pregnancy. She's not acting like her first pregnancy," that the possibility of abdominal pregnancy occurred to me. In about an hour a careful review of the history, a sterile pelvic examination, and a flat plate of the abdomen confirmed the diagnosis.

As in the illustrative case reported, a history suggesting a ruptured ectopic pregnancy is often obtained. This is followed by a relatively asymptomatic period, during which the patient may complain of occasional abdominal pains and tenderness, particularly on fetal movement. The patient often continues past her expected date of confinement and is usually discharged from the hospital two or more times as "false labor."

A persistent unexplained anemia may occur throughout the pregnancy. Examination usually

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reveals a high and abnormal presentation of the fetus, and an X-ray may demonstrate this, with a soft tissue mass below the presenting part. The X-ray films may, at times, be misleading, as in Deming's case[14] in which an X-ray film at term showed "an intra-uterine pregnancy with the fetus at term lying in the left occiput anterior position, vertex almost engaged . . . the placenta is situated high up in the upper segment of the uterus slightly to the left and posteriorly."

The sterile pelvic examination usually reveals marked displacement of the cervix, which is soft, long, and closed. A soft tissue mass may be palpable in the cul-de-sac, where a portion of the placenta usually extends. When palpation of the interior of the uterus fails to reveal membranes or presenting part, the diagnosis is confirmed.

The "pitocin test," in which an attempt is made to produce a uterine contraction,[15] has been utilized in confirming the diagnosis. Greenhill[16] collected 7 cases from the literature in which hysterography confirmed the diagnosis. Except in very rare cases, these procedures are unnecessary. Once the possible diagnosis is entertained, it can be made by history, physical examination, and X-ray films.

MORTALITY

In an attempt to determine the fate of viable, living babies in extra-uterine pregnancies, Suter and Wichser[17] reviewed 41 cases from the literature and presented 4 new cases. The authors concluded that one fourth of all the extra-uterine pregnancies diagnosed after the fifth month of gestation will result in viable, living babies. About one third of these will have major or minor defects. Approximately one half of the viable, living babies of extra-uterine pregnancies will survive 8 days or more.

Hellman and Simon[18] collected a total of 316 cases between 1809 and 1933. Of these, one half or 158 fetuses were viable. In this series the maternal mortality was approximately 33 per cent. Of 80 cases in which both mother and baby survived, probably in no more than 50 were they entirely well.

H. H. Ware, Jr.,[12] in reviewing 251 babies born of extra-uterine gestation of more than 28 weeks, found a total fetal mortality of 75.6 per cent. In 13 cases of late extra-uterine pregnancies the maternal mortality was 30.76 per cent. L. H. Douglass in discussing this paper reported almost identical figures: a maternal mortality of 30.77 per cent and a fetal mortality of 77 per cent in 26 cases.

Many babies developing in an abnormal environment have defects which are incompatible with life. In the case presented, respirations could not be established. Autopsy revealed the lungs to be dark brown, and much old aspirated material escaped from the terminal bronchi when the lung was cut; the interesting microscopic picture (figure 1) showed the lungs to be packed with old blood, plasma, and debris. This probably resulted from long-term aspiration of old blood in the abdominal cavity due to the fetal anoxia resulting from the patient's severe anemia.

PLACENTAL MANAGEMENT

Great care must be exercised in entering the abdomen in a case of suspected abdominal pregnancy. It is not unusual for the placenta to be attached to the lower anterior parietal peritoneum or the omentum. It may be necessary to extend the incision considerably to avoid the placenta. Unless the implantation is obviously on a removable organ such as omentum and tube or spleen, extensive exploration should not be undertaken. Experience of others[13] has shown that excessive blood loss occurred only when the placental attachment was disturbed. Luria[19] reopened his case 2½ hours after the original operation to control hemorrhage from a slight separation of the placenta which he believed occurred when the baby was delivered. His patient recovered after receiving 7,500 c.c. of whole blood in a 6-hour period.

As early as 1919, after some animal experimentation, Beck[20] advocated leaving the placenta in situ and closing the abdomen without drainage if the blood supply could not easily be ligated. Others have handled the problem with manual removal and gauze packing. Marsupialization has its advocates. Some have drained the abdomen after leaving the placenta in situ. All of these cases reviewed by me were reported as having very stormy postoperative courses. Possibly this was so because of the original indication for drainage. Most authors [2, 8, 11, 12, 13, 21-25] agree that, in general, the method advocated by Beck gives the best results.

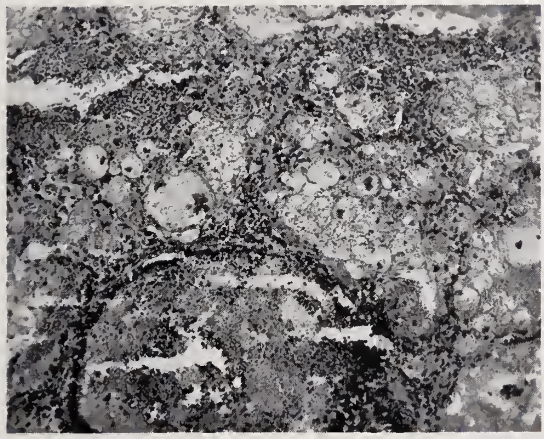

FIG. 1. Fetal lung, showing complete engorgement of bronchioles and alveoli with erythrocytes, mononuclear cells, fibrin, debris, and eosinophilic coagulum. (A.F.I.P. neg. no. 53-23503 X145)

Most of the patients treated in this way will survive. Gustafson[3] emphasized that it is wise to remove only those placentae located within a sac (i.e., tubal, tubo-ovarian, and tubo-interstitial pregnancies). Dabb[26] also encountered surprisingly little bleeding on removing a placenta within a sac.

Barrett[27] suggested that the placenta can usually be removed in those cases in which the fetus has been dead several days. He also advocated removing the placenta with a live baby and controlling hemorrhage by packing with gauze. Four of the 5 mothers survived after stormy postoperative courses. In another case, in which a dead but unmacerated 8-pound fetus was delivered, the placenta was entirely removed, with profuse hemorrhage. This necessitated a supravaginal hysterectomy and left salpingo-oöphorectomy in a 22-year-old primigravida in order to control the hemorrhage.[28] Since there is no connection between the fetal and maternal circulation, it seems illogical to suppose that the maternal vessels will thrombose in a short time after fetal death. It takes weeks and sometimes many months before a dead placenta results from disuse. Wolfe and Neigus[2] suggest that, after pseudolabor and fetal death, surgical intervention should be deferred until chorionic gonadotropin is absent. They state that the thrombosed placenta, fetus, and sac may then be safely removed. Most authors believe surgery should not be delayed because of the danger of sepsis, particularly when the placenta is attached to the gut. Ware stated that he has obtained positive Friedman tests for 35 and 47 days respectively after leaving the placenta in situ.[13] In my case the placenta was removed approximately 2 months after the original operation, with profuse hemorrhage. Microscopic examination of the placenta showed large functioning vessels and some apparently functioning villi (see figure 2). The thought that the placenta may be removed safely if the baby is dead would not seem to be valid; it gives a false sense of security, and should be abandoned.

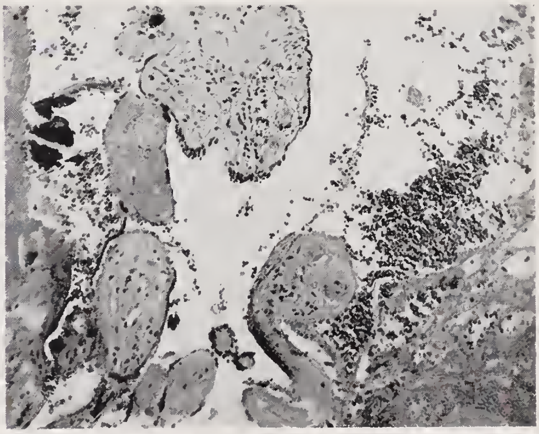

FIG. 2. Placenta section, showing partially hyalinized villi covered by viable trophoblasts and erythrocytes in intervillous space. (A.F.I.P. neg. no. 53-23505 X145)

One must be very patient in awaiting subsequent absorption of the retained placenta. In the case presented, the placental mass appeared to increase in size (as a result of edema and congestion) and seemed tense and cystic 2 months after the original operation. Expectant and symptomatic treatment at this time would probably have saved the patient and the physician a great deal of blood, grief, and a stormy postoperative course. Liquefaction and absorption may take a very long time. Branscomb[29] found a mass the size of a 6 months' gestation 8 months after operation. Studdiford is quoted as noting a persistent mass 13 months after surgery.[2] MacGregor[11] describes the placenta as the size of an orange 16 months after operation. In Jarrett's case[23] the placenta was represented by a mass 7 cm. in diameter 6 months after surgery. Lawler[24] could feel the placenta as a persistent swelling which did not show any decrease in size until the fifth month. Half a year after the operation it was a tense, nontender, cystic swelling about the size of a 14-weeks' cyesis. Pearson and Parks[30] reported a case in which a cystic mass 20 cm. in diameter filled the lower abdomen approximately 3 months after delivery of the baby which they removed by doing a supracervical hysterectomy, bilateral salpingo-oöpherectomy, and appendectomy. They stated, "The placenta did not absorb or suppurate but became encapsulated by bowel and omentum." Simpson[25] reported a case in which the placenta was removed a year after delivery and was represented by a mass 12 by 11 by 8 cm. I agree with Ware that secondary removal of the placenta is unwise unless dictated by complications requiring surgical intervention such as intestinal obstruction.

Since there is no physiologic mechanism for spontaneous separation of the intra-abdominally implanted placenta, it may be wise to drain the fetal blood and leave the cord untied. Torpin believes this would prevent the development of a large placental cyst.[13] By decreasing the total volume it would further facilitate subsequent absorption. There should be little danger of placental separation if this is done gently. Draining the placenta and leaving it in situ has also been suggested in the conservative treatment of placenta accreta in order to facilitate absorption.[31]

REPORT OF CASE

E. D. (246624), a 24-year-old Negress secundigravida, whose last menstrual period was July 2, 1952 and whose expected date of delivery was April 8, 1953, was first seen in the clinic on September 23, 1952. Her first baby, a 6 lb. 3 oz. female, was delivered uneventfully on February 14, 1947. A diagnosis of a 10-week intra-uterine gestation with adequate pelvic measurements was made at this time. She was found to be type AB, Rh positive, and the routine laboratory work was within normal limits. The prenatal course was uneventful until February 7, 1953, when the patient complained of intermittent, slight, lower abdominal pain of 24 hours' duration. There was no vaginal bleeding. Intermittent vomiting had occurred for 2 or 3 days. On physical examination the patient appeared dehydrated and in distress and was immediately admitted to the hospital. The temperature was 99° F., the pulse rate 96, the respiratory rate 18, and the blood pressure 150/90. On abdominal examination the uterus was found to be enlarged to approximately 28 weeks' gestation with diffuse tenderness throughout. No masses were palpable. The fetal heart beat was heard in right lower quadrant at 150 per minute. The admitting physician's impressions were: (1) threatened abortion, late, (2) hyperemesis gravidarum?, and (3) dehydration. On admission the white blood cells numbered 15,750, with 72 per cent polymorphonuclears and 28 per cent lymphocytes. The hemoglobin was 4 Gm., or 13 per cent. Repeated hemograms were similar. A consultant did not believe a surgical abdominal condition existed. The diagnosis of sickle cell anemia with abdominal crisis was entertained, but no laboratory evidence of sickling could be found. The abdominal pain gradually subsided, and she received 2,000 c.c. of blood during this 21-day hospitalization. She was discharged on March 2, 1953 with the diagnosis of secondary hemolytic anemia, cause undetermined, and pregnancy, uterine, 34 weeks, not delivered.

The patient was then followed in the clinic, where it was believed that she had an intra-uterine pregnancy, breech presentation. Her hemoglobin stayed in the vicinity of 10 Gm.

The patient was subsequently admitted to the hospital on March 24, 1953 and April 21, 1953, respectively, apparently in "false labor." It was believed on both occasions that she had a breech presentation of an intra-uterine pregnancy. The fetal heart tones were good, and only "irregular contractions" were noted.

The patient was finally admitted on May 10, 1953, 29 days after her expected date of confinement, apparently in early labor. The breech was presenting high, and the cervix was undilated. In view of the "missed labor" and the husband's feeling that "something was very wrong" with this pregnancy, the history was reviewed and the patient carefully examined. The possibility of abdominal pregnancy came to mind, since the fetal small parts seemed superficial and the fetal heart tones easily audible. On rectal examination an irregular soft, nontender mass seemed to be filling the cul-de-sac. On sterile vaginal examination the cervix was found to be soft, long, slightly patulous, and displaced anteriorly. Neither membranes nor presenting part could be felt in the uterus. A soft tissue X-ray film of the abdomen revealed a symmetrical soft tissue mass which seemed to be filling the pelvis. The fetus was lying high, in an obliquely transverse presentation with the head on the right.

The diagnosis of post-term abdominal pregnancy with living baby was made and the patient prepared for surgery. A laparotomy revealed an apparently normally developed fetus at term lying free in the abdominal cavity, which contained approximately 1,500 c.c. of old, dark blood. The baby's extremities were enveloped by loops of bowel, and the head rested beneath the liver. The female baby was extracted at 11:05 p.m., May 12, 1953. She made a few attempts at inspiration but failed to respond and expired at 11:25 p.m. The placenta was implanted over the pelvic organs, extending from the anterior parietal peritoneum to the rectosigmoid. The cord was tied close to the placenta, which was not disturbed. There was no evidence of an amniotic sac. The patient had a remarkably uneventful postoperative course and was discharged in good condition on May 28, 1953. On discharge there was slight tenderness in the lower abdomen, and a soft mass was palpable extending out of the pelvis about 4 cm. suprapubically.

Autopsy on the baby revealed the lungs to be dark brown, and much old aspirated material escaped from the lung tissue when it was cut. Microscopically the alveolar spaces contained a large amount of plasma, cells, and epithelial cells. The rest of the autopsy was unremarkable.

The patient was then followed at weekly intervals in the clinic. Although she felt well, the placental mass seemed to be gradually enlarging. She complained of rather severe lower abdominal pain and some vaginal bleeding when she was seen on July 2, 1953, 51 days after the original surgery. Examination revealed a tense, tender mass reaching 3 cm. above the umbilicus, extending bilaterally to the pelvic walls. On pelvic examination the cervix was displaced anteriorly and downward, and the mass filled the pelvis. It was thought by both the attending physician and a consultant that the mass probably represented liquefaction of the placental tissue which could easily be evacuated through an abdominal incision. It was believed that the maternal vessels of the placenta would be thrombosed by this time and that the procedure would not be complicated by severe hemorrhage.

The patient was admitted to the hospital and reopened. A large, edematous, friable placenta was found that had become encapsulated by bowel, omentum, anterior abdominal wall, and pelvic organs. During its removal profuse hemorrhage ensued and the patient rapidly went into profound shock. An arterial cut-down was performed in addition to a venous cut-down, and whole blood, dextran, and serum albumin were administered. The pulse and blood pressure returned, the bleeding was controlled with sutures and gelfoam packings, and the patient was returned to her room in critical condition. A total of 3,000 c.c. of whole blood was administered during and immediately following the procedure as well as 300 c.c. of serum albumin and 1,000 c.c. of dextran. The patient had an extremely stormy postoperative course and was finally discharged after a 2-month hospital stay. On November 8, 1953 she was seen in the clinic. She had no complaints and was in good condition.

SUMMARY AND CONCLUSIONS

1. The literature has been reviewed and a case of abdominal pregnancy with secondary removal of the placenta has been presented. Profuse hemorrhage occurred when the placenta was removed 51 days after the original operation.

2. The incidence of abdominal pregnancy varies considerably with different areas and population groups. The incidence has been reported as ranging from 1:2,207 deliveries to 1:16,370 live births.

3. The key to the diagnosis is the physician's awareness of the possibility of abdominal pregnancy. Once the diagnosis is entertained, it can usually be made without difficulty.

4. The fetal mortality is about 75 per cent and the maternal mortality about 30 per cent. Many of the babies have congenital deformities incompatible with life. Of the cases in which both mother and infant survive, about 40 per cent of them are not entirely well.

5. The placenta should be meticulously avoided on entering the abdomen and in extracting the fetus. Unless the blood supply can be easily ligated, or is located within an easily

removable sac, it should be left in place. It would probably be wise to drain the fetal blood and leave the cord untied in order to facilitate subsequent absorption and prevent the development of a placental cyst. Experience of many contradicts the thought that the placenta may be removed safely if the baby is dead for a short time. This idea gives a false sense of security and should be abandoned. If removal is contemplated, it should be avoided until the absence of chorionic gonadotropin hormone indicates a "dead placenta."

6. Absorption of the placenta often takes a very long time and should be patiently awaited. Secondary removal of the placenta is unwise unless dictated by complications requiring surgical intervention such as intestinal obstruction.

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THE BASAL METABOLIC RATE AND SUGAR TOLERANCE

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WHILE studying the relationship between the basal metabolic rate and the blood plasma cholesterol, a study which is still in progress, it was essential and necessary to determine also the blood sugar level of the same patients, in order to exclude diabetes, since it is known that the blood cholesterol in diabetics is frequently elevated.

The influence of the thyroid gland on metabolism in general and on the metabolism of particular foodstuffs has been extensively studied by various authors.

It has been demonstrated conclusively that the administration of thyroxine, the thyroid hormone isolated by Kendall in 1918, is followed, both in man and in the experimental animal, by a considerable increase in the nitrogen output. The increased nitrogen metabolism is believed to express the breakdown of proteins. Many experiments may be cited which indicate that the thyroid plays an important role in protein utilization by the body.

The influence of the thyroid on the carbohydrate metabolism or carbohydrate utilization in the body may be shown by the studies on the blood sugar. Animals or humans fed thyroid substance in the desiccated state or thyroid extract are frequently seen to have hyperglycemia and occasionally glycosuria. It has been found also that the total abolition of the thyroid gland increases sugar tolerance roughly parallel to the decrease of the metabolic rate.

Even though it has been clearly established clinically and experimentally that the thyroid has an influence on, or participates in other metabolic body processes, as, for instance, in lipid metabolism, in the electrolyte balance of the body tissues, and therefore in the water metabolism of the body, I have limited this study to only one phase of the thyroid, namely, its influence on the sugar tolerance as demonstrable by a fasting blood sugar. In order not to prejudice the results, 100 patients were chosen, irrespective of age or sex, from a group of 147 who came to the office with some minor complaints which had no reference to thyroid function. In each of these a basal metabolic rate and a fasting blood sugar were obtained under the usual standard conditions.

It is well known that the basal metabolic rate determination is not an accurate index of thyroid function and is subject to many errors. This fact must be borne in mind in evaluating these data.

The results obtained are summarized in table 1. Fifty-three of the patients were females and 47 males. The ages of the patients varied from 17 to 78 years.

In 11 patients the blood sugar values were definitely abnormal varying from 127 to 270 mg. per cent. The BMR values of these patients varied from minus 6 to minus 25 in 7 patients and from plus 7 to plus 36 in the other 4 patients. The age of this group of patients varied from 48 to 78 years.

In the remaining 89 patients the blood sugar value ranged from 60 to 120 mg. per cent. In 25 patients of this group of 89 the BMR values varied from plus 1 to plus 90. The age range of this group was from 31 to 77 years.

No consistent relationship was observed between the degree of abnormality of the basal metabolic rate and the fasting blood sugar value; i.e., a higher result is not necessarily followed by

TABLE 1

Basal Metabolic Rate and Blood Sugar Levels in 100 Patients

CASE NO.	AGE	SEX	BMR	BLOOD SUGAR	CASE NO.	AGE	SEX	BMR	BLOOD SUGAR
				(mg. per cent)					*(mg. per cent)*
1	49	F	−17	143	51	50	F	−40	95
2	53	F	−15	127	52	28	M	−34	75
3	48	F	−20	143	53	70	M	−30	91
4	50	M	−10	90	54	43	F	−6	92
5	39	M	−22	79	55	46	F	+3	87
6	43	F	−22	82	56	50	M	−7	81
7	50	M	−23	117	57	34	F	−12	104
8	37	M	−14	96	58	31	M	+24	87
9	52	F	+7	89	59	36	M	−19	84
10	60	M	−25	133	60	52	F	+3	94
11	71	M	−27	91	61	37	F	+7	87
12	32	M	−17	89	62	53	F	+55	105
13	71	F	−22	232	63	53	F	Normal	97
14	43	M	−25	97	64	60	M	−40	76
15	33	F	−60	95	65	72	F	+50	102
16	55	F	−20	101	66	56	F	+50	76
17	42	F	−40	95	67	56	F	+7	130
18	46	M	−40	100	68	67	F	+12	73
19	42	F	−20	110	69	78	F	+15	166
20	52	M	−36	83	70	39	F	−28	73
21	56	M	−35	91	71	71	M	+45	73
22	47	F	−17	83	72	44	M	−14	80
23	71	F	−21	104	73	52	F	+90	101
24	27	M	−31	90	74	17	M	−7	94
25	44	F	+14	97	75	63	M	−4	78
26	42	M	−17	70	76	51	F	−34	120
27	47	M	−22	81	77	62	M	−12	128
28	62	F	−6	96	78	78	F	−39	101
29	57	F	−26	94	79	35	F	+50	81
30	51	F	−17	106	80	35	M	−40	71–110
31	34	M	+4	96	81	72	F	−15	46–71
32	44	F	−3	80	82	54	M	−40	115
33	64	M	−26	85	83	57	M	−35	97
34	53	F	+55	89	84	45	F	−6	110
35	55	M	−17	60	85	50	M	+1	112
36	31	F	+15	74	86	53	M	+23	115
37	52	F	+6	65	87	31	F	−29	115
38	63	F	−6	152	88	51	M	−17	106
39	33	F	−7	65	89	65	F	−21	106
40	42	M	−17–14	106	90	52	F	−9	97
41	52	F	−9	270	91	38	M	−24	80
42	77	F	+45	106	92	65	M	−12	101
43	52	F	+3	87	93	55	M	+40	120
44	48	F	−28	81	94	39	F	+20	110
45	36	M	+9	86	95	62	M	+1	74
46	41	M	+40	76	96	53	F	−1	101
47	52	M	+9	94	97	59	M	+36	140
48	65	M	−32	87	98	49	F	−6	77
49	48	M	+25	74	99	58	M	−7	103
50	55	F	−23	81	100	49	M	−31	94

a higher fasting blood sugar value. As examples, case 85, a man 50 years of age, gave a BMR value of plus 1 and a fasting blood sugar value of 112 mg. per cent; case 86, a man 53 years of age, gave a BMR value of plus 23 and a blood sugar value of 115 mg. per cent; case 73, a woman 52 years of age, showed a BMR value of plus 90 and a fasting blood sugar value of 101 mg. per cent; case 93, a man 55 years of age, had a BMR value of plus 40 and a blood sugar value of 120 mg. per cent.

In the remaining 64 patients, varying in age from 28 to 71 years, all the BMR values were minus, varying from minus 6 to minus 40, and all the blood sugar values were below 120 mg. per cent. Also, in this group of patients no parallel was found between the degree of lowered BMR and the blood sugar value. For instance, case 46, a man 41 years of age, had a BMR of minus 40 and a blood sugar value of 76 mg. per cent, while case 17, a woman 42 years of age, gave a BMR value of minus 40 and a blood sugar value of 95 mg. per cent, and case 18, a man 46 years of age, had a BMR of minus 40 and a blood sugar value of 100 mg. per cent. Case 7, a man 50 years of age, had a BMR of minus 23 and a blood sugar value of 117 mg. per cent.

Neither age nor sex were found to have any consistent relationship either with the basal metabolic rate or the blood sugar values; i.e., plus and minus BMR values and variable blood sugar values (in the nondiabetics) were found in a more or less similar frequency in both sexes of all ages.

SUMMARY

1. In 7 of the 11 patients with abnormally high sugar values, i.e., in 63 per cent, varying degrees of lowered basal metabolic rate (minus 6 to minus 25) were present, while in 4 patients of the same group, i.e., in 36+ per cent, varying degrees of increased basal metabolic rate (plus 7 to plus 36 per cent) were found.

2. In 25 of 89 patients, roughly in 27+ per cent of cases, low blood sugar values were associated with various degrees of elevation of the basal metabolic rate (BMR values of plus 1 to plus 90 per cent).

3. In 73 per cent of the 89 patients, low blood sugar values were accompanied by various degrees of lowered basal metabolic rate.

4. Neither age nor sex were found to have any definite or constant relationship to the basal metabolic rate.

5. An increased sugar tolerance in association with a lowered basal metabolic rate was found in only 71 per cent of the entire group of 100 patients studied.

6. It is well known that the basal metabolic rate is not an accurate index of thyroid function and is subject to many errors. This fact must be kept in mind in an evaluation of the data of this study.

THE OBSESSIVE-COMPULSIVE NEUROSES*

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DEPRIVATION of love and affection is commonly associated with emotional illness. To be genuinely wanted upon arrival, and later, is a vital factor to the emotional security and maturation of the child. In certain instances of emotional sickness the realness of the deprivation felt or reported may be subject to question. In my experience, however, I have never worked with a patient with obsessive manifestations who was not genuinely deprived in some measure of love and affection in early life. This observation has been further corroborated recently by the opinions of certain respected colleagues whose cumulative clinical psychiatric experience is well over 100 years.

Thus we continue the study of the particular psychologic defensive pattern already begun in "The Obsessive Personality." The obsessive is a person who is extremely vulnerable to anxiety. He may feel threatened by almost anyone. In desperate defense against anxiety he has erected beyond conscious awareness a system of attempted protection. As we have seen, this may include certain character traits which fall into an obsessional pattern and which may prove adequate or break down under added stress. These defensive traits in similar fashion to neurotic symptoms, which can supersede them when they are inadequate, develop as protective devices against the intense subjective and often hidden emotional feelings of the obsessional. Actually, separate discussion of the obsessive character defenses from obsessive neurosis does not indicate major differences in dynamics nor in treatment, and the largely descriptive material already presented should be considered a requisite introduction to what is to follow.

Descriptive and Clinical Features

The clinician must constantly keep in mind that obsessive character traits and obsessive symptoms develop in response to powerful internal psychologic needs. The analysis of every obsessional manifestation eventually reveals this. Essentially the purpose of each is to avoid anxiety. The developing child intuitively adopts defensive mechanisms which work best in his particular interpersonal environment. This process is so automatic and so outside of his conscious awareness and direction as to be comparable to certain phases of the process of physical growth. The result is the development of individual character defenses (traits) which many times are obsessional ones.

In some degree or other we have noted earlier the ubiquitous incidence of obsessive defenses. While this has long been true, until relatively recently the basis for their appearance remained a mystery. It was not until 1894 that Freud[1] presented his early observations concerning the psychologic etiology of obsessions. By this time he had collected enough data to relate the appearance of the obsession to the repression from conscious awareness of unbearable ideas and he was able to illustrate this clinically. These ideas were believed at this stage of study and research to be primarily sexual. In the complex process which took place, a detachment of feeling (affect) was made from the original intolerable idea and was then displaced to another more tolerable one. This sequence occurred out of conscious awareness. When awareness could be secured through free association, study and analysis, the defensive need for the obsession decreased. Thus a method of treatment became available.

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* This paper was presented in connection with postgraduate medical teaching programs in psychiatry to the Department of Neuropsychiatry, Walter Reed Army Hospital, Washington, D. C., April 8 and 15, 1954; to psychiatric Residents-in-training, St. Elizabeths Hospital, Washington, D. C., March 30 and April 6, 1954; and, in part, to the Resident Staff, Suburban Hospital, Bethesda, Md., March 18, 1954.

This, the eighth article in a series by Dr. Laughlin covering the psychoneuroses, is being published in two parts, of which this is Part I. Part II will appear in the June issue of the Medical Annals.

Together with data worked out concerning hysteria, the knowledge gained from the study of cases of obsessional neurosis became the early cornerstone of dynamic psychiatry. Freud[2] soon grouped obsessional neurosis together with anxiety neurosis and hysteria as the emotional illnesses most accessible to psychoanalytic therapy, referring to them as the "transference neuroses." He used this term to indicate the basic capacity of these patients for developing "transference" of emotional feelings (i.e., feelings which were originally experienced toward others, particularly significant persons from early life) to the therapist, a requisite for successful analysis. While these types of cases continue to be regarded as favorable prospects for treatment, in the last 30 years the application of psychotherapy has been successfully undertaken with additional types of cases earlier regarded as poorly accessible or inaccessible to treatment. As the understanding of dynamics has further developed, we have also come to increasingly recognize the important role of unbearable hostile, destructive, and aggressive impulses, in addition to disowned ones of a sexual nature, in the etiology of the obsessive-compulsive reactions. We have come to learn more about their relation to anxiety and the internal psychologic needs which they meet or attempt to meet, the endogain (primary gain) of the emotional illness.

As we shall learn in our discussion of dynamics, the important mechanism in obsessive neurosis is one of displacement and substitution, displacement of affect and substitution of object.* Obsessional neurotic symptoms occur when existing ego defenses (the mental mechanisms) are inadequate or break down, usually under additional stress, often a sudden or acute one. When the stress has been gradual and steady, the development of defensive character traits may suffice. These in turn may become exaggerated, may prove inadequate, may be reënforced, or to some extent may even be replaced by actual neurotic symptoms as the response to added stress (the threat of derepression and the breaking through into conscious awareness of the intolerable ideas). In turn, if the threat literally overwhelms the defenses, a psychosis may ensue. Psychiatrists have occasionally observed patients in whom the anxiety present had mounted to an unbearable peak, to be followed literally by the overnight onset of a psychotic episode in which there was little outward evidence of anxiety.

At this point we might consider how displacement and substitution can operate as a defense against anxiety. In the following example, when disowned rage threatened to come into conscious awareness during treatment sessions, an obsessively repetitive train of thinking ensued. The repetitive thought replaces the more disturbing one as a defense against the anxiety which it produces.

Case. 1 This patient was a 31-year-old physician who had sought analysis because of certain limitations in his interpersonal relations and in order to improve his professional effectiveness. He was an able, conscientious, and hard-working person who enjoyed the respect of his professional colleagues. Among his character defenses were some rather prominent ones of an obsessive nature. During the second year of psychotherapeutic work a recurrent, obsessive pattern of thinking and reaction was noted during treatment hours.

On these occasions the patient would recall a certain incident from his early life and focus his attention upon it with expressions of guilt and dismay. "After all it was I who did such a terrible thing. I guess I'm a pretty bad person really. I feel terribly guilty. This prevents me from having any confidence in myself. No one could really respect me if they really knew me. I guess I'll never get any place professionally, etc., etc." As one might expect, the reaction was far out of proportion to any realistic appraisal of the incident recalled. However, it served quite effectively to divert attention from much more uncomfortable areas, the recall of which was threatening to him and thereby anxiety-producing.

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* Displacement and substitution are mental mechanisms or dynamisms which occur out of conscious awareness. They may be defined as follows: Displacement: "The transfer of emotion from its proper (original) object to another." Substitution: "An unacceptable goal (or object) is replaced by one which is (more) acceptable."[3]

Gradually it became apparent that the recurring obsessive preoccupation with the early incident arose whenever he came close to a recognition of hidden, disapproved, angry and hostile feelings. These were presumably directed toward his wife because of her rejection of him. He could not tolerate, or rather feared he could not tolerate and control, the amount of hostility aroused. The obsessive line of thought would occur when discussions approached too closely his feelings of rejection in marital areas with his wife, and also with his mother. When awareness of his hostile feelings (derepression) threatened, anxiety was aroused and the obsessive pattern of thinking and feeling descended as a protective curtain. As conscious consideration of his wife's rejection impended, instead of facing the hostility this aroused he evoked the fixed line of thinking. In similar fashion to what we have earlier observed in the dynamics of depression, the hostile reaction was turned inward (inverted) and redirected seemingly toward himself.*

Thus, he evoked in substitution the fixed line of thought, "I've been so bad. I feel so guilty" as tolerable in place of more threatening current hostility. As we gained awareness together of the basis for this pattern of defense, it became no longer necessary. He became able to understand and to accept the erstwhile hidden emotions without anxiety or fear, an important goal in therapy. There are other deeper roots present, of course. In partial and stringent summary, the primordial rejection was by his mother who was psychologically unable herself to give him much genuine warmth and affection. The great frustration and disappointments resulting inevitably aroused a level of rage and resentment which could seemingly not be faced. His relationship with his wife partly rekindled and recapitulated the earlier childhood conflicts. His own early deprivations limited the amount of warmth and affection he could direct toward his own children in turn. As he became able to recognize more about the defensive efforts of his other obsessive patterns to circumvent anxiety and the basis for the latter, they became also less necessary. Over the course of several years of intensive therapeutic work he became ably to enjoy a fuller and more satisfying life.

Sometimes one can note the presence of obsessive character traits as indicating a diathesis for the possible development of a later obsessional neurosis. The obsessive-compulsive reactions in various degrees are most common. This is particularly true of milder cases and very much so with the obsessive character defenses. In current psychiatric practice the very severe obsessional neurotic is not very common. A reverse impression may sometimes inadvertently be created, however, in view of the severe type of case which is usually selected for presenting in clinical illustration. These are frequently picked on the basis of unusual or striking features, the completeness of the understanding of the underlying dynamics, or perhaps simply because they are more severe, more unique, and therefore more outstanding. It is certainly true that in the more severe cases the patient can become one of the most tortured of individuals. Indeed, when one sees how terribly worrisome the secondary conscious struggle can become against the intrusion of the unwanted obsessive idea or compulsion, the level of disturbance of the still more avoided (unconscious) impulse which it replaces is most awesome.

An obsession is an insistent, repetitive, and often unwelcome thought. A compulsion is an insistent, repetitive, and unwanted urge to act. As Bleuler[4] stated, "It is anxiety that makes it impossible for the patient to suppress the impulse (i.e., in compulsions; also the thought in obsessions) in spite of the fact that he is willing and knows better." Thus, the intrusion of the unwelcome thought may prevent anxiety by serving as a substitute for an even less welcome one, as we saw illustrated in case 1. In similar fashion, the performance of the compulsive act relieves tension and anxiety, which appear when the patient resists or attempts its omission.

Obsessive thoughts vary greatly in severity, degree and pathologic significance. Commonly experienced as a mild and often nonpathologic example is the persistence of a musical theme or a phrase as read or heard. These may or may not persist and may cause no interference in living. At times one might attempt to expel a troubling recurring idea or mental theme from mind with little success. In the following case an obsession with cleanliness was most severe and handicapping.

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* The psychoanalyst is aware here that actually the object is introjected and sadistically punished in secret fashion, at the same time ensuring a certain degree of self-punishment.

Case 2. A 28-year-old, unmarried business machine operator sought help for a compulsion to wash his hands and for certain other problems in living. His hands were reddened and sensitive from the thorough scrubbing received on a daily average of 25 times or more. Occasionally when his level of anxiety became quite high the frequency increased greatly. He had to carefully clean the keys of his machines with disinfectant before and after each use. In dressing he handled his undergarments through sterile tissues, and if his shoes touched any item of clothing he had a strong impulse to destroy it. He feared he would contaminate people he contacted. He could not stand to brush against another person, and, if this happened, dry-cleaning of his garments was a necessity, although even this did not always result in his feeling comfortable. Occasionally he destroyed by burning certain items of personal property.

He could not handle food or eating utensils, explaining his inability to do so on the basis of some vague dread thing which would happen. This patient's efforts to avoid "contamination" of himself or of others had become a major endeavor, requiring the investment of much time and effort which could well have been more constructively utilized elsewhere. Although we cannot consider here the complex dynamics in this case, some of the important pathogenic features were worked out. The ritualistic washing represented symbolically efforts to secure moral purity. His "ability to contaminate others" in part reflected his extremely low level of self-esteem.

It is a common finding that children are likely to go through stages of compulsive behavior. Thus, they may feel the need to avoid or touch, for example, every crack in the sidewalk, the fifth picket in a fence, or every light pole. These phenomena usually have no pathologic significance and seldom persist. On the other hand, Freud[5] made the observation that "the first symptoms of obsessional neurosis declare themselves in the second period of childhood (from six to eight years of age). . . ." It is also to be noted that certain children show evidence of obsessive character traits at this time which often then recede to some extent, although they may actively or latently become a firm part of the personality structure.

Parents are less likely to become concerned over the presence of obsessive character formations, early obsessive symptoms, or the beginning diathesis for later obsessional neurosis than they are over some other emotional situations. This is true, since in many instances the parent is consciously seeking "maturity," control, and the suppression of unwelcome emotions by his child and may be inclined to accept the above as evidences of success. Also, the parent may be somewhat obsessional himself. This may help account for the relatively fewer obsessionals seen by child psychiatrists. Kanner[6] has pointed out that it is rare to have children brought for consultation because of obsessive difficulties before 14 or 15 years of age.

Much has been written about the hostility masked by obsessive traits or symptoms and the limited capacity of the obsessional for affection. I have noted how the former arises from the frustration resulting from parental rejection or the setting of sickeningly difficult standards and goals. One must see also how the deprivation of parental love and affection actually results in turn from parental inability to provide it. In certain instances one sees great conscious efforts by parents to make up for this lack. A studied facade and pretense are often a sad substitute for the genuine article. Likewise, children are quick to intuitively grasp the underlying real rejection of both conscious and unconscious compensatory efforts, for example, as overprotectiveness or overindulgence, with insecurity and anxiety resulting.

In passing I might point out here that hostility is not always a negative force. It may be divided into two major categories: First, there is destructive hostility. This is the type which is injurious to others and not necessary for self-preservation and maintenance. Second, there is the hostility which consists of constructive aggressiveness. The latter is necessary to protect one's rights and includes healthy self-assertiveness.

As to the limited capacity for affections, the child who has lacked warmth, acceptance, understanding, and affection will in turn be limited in his capacity to provide them for his own children. The possible vicious implications in this cycle are frighteningly apparent.

The limited capacity for affection may be regarded also as part of the over-all general inhibition of feelings. This inhibition has been developed as defensively necessary to guard against forbidden hostile and sexual impulses, frozen from childhood. Further, affection is protectively restricted in similar fashion to the increased caution around fire by one who has been burned—"Once burned, thrice wary."

In this connection I must refer again to the terrific vulnerability of the obsessive. Having been so repeatedly injured, frustrated and rejected, it is not surprising that a frequent prominent aspect of his resulting psychologic defensive system consists of distance-promoting operations. In other words, part of his protection against injury from people is to keep distant. As one contribution toward maintaining such distance, there is the faculty of being overly critical. This need, which often also operates as an ego-boosting endeavor to combat low self-esteem, inevitably promotes distance in relationships. They may become difficult or impossible. The threat implicit thereby is avoided, i.e., the danger of further hurt and rejection. The basis of criticism made varies according to the strength of the underlying inner need present and may include almost anything about a given person, such as personal characteristics, clothes, possessions, appearance, manners, prestige, position, friends, odor, make-up, speech, family, education, age, and experience. Not infrequently, when this is operative, the obsessive adds to his resulting further deprivation, loss and misery by expecting via projection (the assignment to others of his own motives, feelings, reactions, etc.) that similar harsh judgments are constantly being made of him by others.

Satisfactory relationships with the opposite sex may be similarly (and defensively) impeded. A failure to make adequate advances may be rationalized on the basis of such criticisms as above, fastidiousness, apparent ethical considerations, time, circumstances, etc. At times such factors may operate as additional controls to strong but feared sexual drives. In other instances obsessive-compulsive manifestations may be reflected in the sexual adjustment. For example, there are patients who "control" the sexual act and their partners by various types of activity and behavior. Actually, however, the attempted control here is really of inner anxiety. In other instances one may see compulsively motivated frequency of intercourse as an attempt to meet torturing inner and hidden doubts as to potency, manliness, femininity or maturity.

At an earlier point in these discussions I have noted how the mature and mutually satisfactory sexual relationship constitutes perhaps the most complex achievement in interpersonal relations. Undoubtedly it is the most intense. It is not surprising, therefore, when emotional difficulties occur, that the adequacy of the sexual relationship frequently mirrors or reflects the situation. The balance in this area is more intricate and more easily disturbed. In view of the very frequent involvement of problems of sexual adjustment in all types of emotional illness, it is not surprising that some have tended to regard these disturbances as cause, when they may often instead be effect. In other words, certain authorities have tended to regard sexual problems as the cause of the emotional illness rather than the reverse.

To return to the vitally required defense of maintaining distance, this can be a further excruciating source of conflict and misery to the severe obsessive. In consequence of his own early deprivations he concurrently possesses an even greater need for people, warmth, and companionship. Sometimes he must deny this need, even to himself. However, one can see how the obsessively-oriented person may be most vulnerable to loneliness. He is often by himself, sadly unable to bring the conflict between his truly great needs for closeness and his even stronger defensive needs for distance into any reasonable resolution. Even in those relationships established, the obsessional suffers greatly since they are so often directed in part, or accompanied by feelings of guilt and inner discomfort.

Frequently we see in the obsessive the great emphasis placed upon the control of his feelings and affectivity. Often this is an endeavor which was actively or tacitly encouraged by important adults in childhood. In any event, repression was a vital endeavor. Emotions were dangerous and threatening. This held whether they were hostile and aggressive or warm and loving. They constitute a threat, since the possessor fears they will get out of hand and control him instead of the reverse. Parents who have similar fears about their own emotions would rather naturally encourage repression and control in their children, thence all manner of psychologic efforts to "sit on" the emotional feelings such as control, denial, concealment, rationalization, repression and diversion.

As another reflection largely of the little genuine interest shown them in childhood, the obsessive has a diminished capacity for genuine interest in others in turn. Sometimes a pretense or facade of interest was demanded by parents, perhaps even as they demanded this of themselves in turn. This can only lead to more trouble. In later life because of their great needs plus considerable self-criticism, the obsessional may force himself to falsely behave lovingly or obligingly, etc., albeit the less genuine this is, and the more enforced, the more accompanying resentment is aroused in the patient himself.

A super awareness of self, which can be a reflection of low self-esteem and a harsh judgmental conscience in turn, can greatly restrict the ability to enjoy living, to have fun, to relax, or to enjoy a play, concert, or a social occasion. The obsessive may be forced to devote abnormal concern, for instance, to an awareness of the position of his tie, the crease of his trousers, complexion, dress, appearance and/or hair. All of this can operate in the service of restriction and control.

Despite his best efforts, the obsessive failed to secure real acceptance in early life. This ensures a continuing low level of self-esteem perpetuated by the incorporation into his own standards and conscience of the impossible-to-achieve ones of parents. Low self-regard and -esteem is universal with obsessives. Often, however, it has to be defensively denied to self as to others, and the reverse appearance may even be created of overevaluation, superiority, and condescension.

The inevitable low self-esteem may help result in many vital defensive operations which may be socially unwelcome. As one result of the low self-esteem and inner self-doubts, the prestige needs may be high. There may be an exaggerated desire to associate with financially or professionally successful people as a way of trying to belong, to gain acceptance, to be there also. Comparisons with others may become an important, continuing, absorbing, and nearly automatic process. The person may suffer from strong competitive feelings, or ones of envy and jealousy. These may also prevent closeness. Not infrequently they may carry over to some extent into relationships with one's spouse.

Low self-esteem can contribute to the undue and often self-defeating importance of being correct. The harsh conscience burdens the obsessional so that he can poorly tolerate criticism from others. He already carries too great a burden of his own. The importance of words was mentioned earlier. Overattention to them, deliberateness, and studied choice can be a defense against spontaneousness and in this way contribute to control of emotions and emotional display. An obsessional patient recently said to me in rather typically self-critical fashion: ". . . Why do I have such an interest in words? Do I use this as an evidence of my knowing something that someone else does not? Is this a much sought after superiority about some small specific thing? I notice in my writing a studied effort to use the odd and unusual. Then it doesn't read well, which defeats me. Lincoln pointed out the value of not using 2 syllables when 1 would do. Maybe it's an attempt to impress with my eruditeness and scholarliness. . . ."

As one may readily note, the obsessional is his own most harsh critic. To the outside world he is a reserved, good, model citizen. He is apt to appear not so much a hostile person as perhaps a restrained and dull person, the type perhaps which is sometimes boring, intellectual, overly serious, conscientious, and preoccupied. Underneath they are easily frightened and react defensively against any upsurge of bottled-up and frozen inner emotion which might ruffle the seeming outer calm of the dead sea of their personalities. When the defenses and controls work, no need is felt for psychiatric assistance, and it is not sought. When these break down or do not suffice, help is urgently needed.

A reasonably common type of obsessive thought which is very alarming to patients is one in which there is a recurring thought related to harming a family member or members. As this is written I can recall offhand 5 patients seen in consultation in recent months in which this kind of obsessive thought was a principal source of concern. Such thoughts were too repugnant and evil to admit or accept. To the patient they seem almost murderous in themselves. In every instance the patient regarded the thoughts as intolerable, nonsensical, silly, or ridiculous and had strongly tried to suppress them or substitute other thoughts, often encouraged in this type of approach by well-meaning friends or family. Such endeavors are not only likely fruitless but, by directing attention and energy in this direction, they are absorbed elsewhere and to this extent unavailable as well as having been unprofitably directed away from the possibly more constructive approach of inquiry as to its meaning. The following case illustrates this type of problem.

Case 3. The 32-year-old mother of 2 small children came to consultation because of intrusive repugnant thoughts related to their injury or murder. On infrequent occasions her husband was also a "victim." These thoughts were so repugnant to her, made so little sense, and were so foreign to her conscious feelings that she was embarrassed to mention her problem. As a result she had kept it to herself for nearly 2 years despite considerable intermittent difficulty. These thoughts which were so terribly disturbing to her were really not much different from what every normal young woman occasionally feels toward her children. Many a young parent less inhibited and more spontaneous than this one could say, "Oh, today I feel like throwing Johnny out of the window! He makes me so mad!" She would not feel guilty or critical and would forget it.

This patient had to deny all but positive feelings. As a consequence she defended herself against the self-condemnation and guilty feelings about such "terrible" thoughts by denying that they are hers: "It's just awful words that pop into my head and have nothing at all to do with the way I feel." In her early years an insecure and anxious mother had been unable to permit the slightest expression of negative feelings. The child in return had adopted a pattern of constantly affirming only her affection and love, with repression of all negative feelings as unwelcome and unacceptable. This had been reflected in her conscious attitudes toward her own children. Here also any feelings other than loving ones were intolerable. It was observed also that a possible relationship existed between occurrence of the obsessive thoughts and her mother's visits.

I have indicated that obsessive thoughts are substitutions for earlier intolerable ones. Accordingly, at this point one might well ask, what could have existed which was more disturbing than these thoughts, dealing with the murder of her own children? The answer to this question was eventually forthcoming. The patient was the eldest of 3 siblings and was assigned undue responsibility for their care. Further, and realistically, she felt deprived of any reasonable share of affection from her parents. She was inevitably greatly resentful of her younger sister and brother, and fantasied what it would be like if they were not around. She entertained occasional murderous fantasies which were accompanied by tremendous guilt and anxiety and were completely repressed from conscious awareness. Her hostility was replaced in conscious awareness by positive feelings only. One might further note that the impulse which could have preceded the obsessional thought of throwing Johnny out the window might instead have been a spontaneous, warm and loving impulse like throwing her arms around him and hugging him for joy. Such feelings are very threatening to obsessionals, being associated in the past with rejection, hurt and pain. Since great amounts of anxiety are generated when they erupt, they are often automatically and obsessionally replaced by the reverse, by hostile feelings. The analyst sees this in treatment when the arousal of positive feelings may give rise instead to a defensive display of hostile fireworks.

The marriage and small children, together with her need to reject all negative feelings, had out-of-awareness recapitulated in effect the early family and emotional constellation. The children symbolically represented her own siblings, whose destruction would presumably make her the sole object for parental affection and relieve her of odious responsibility. Mother's presence was a kind of stimulus to the complex mechanisms involved, and the husband was occasionally included, being partly considered (unconsciously) another sibling in these instances.

Many variations of this theme are seen. Freud described the case of a young man whose life was greatly restricted by a very severe obsessional neurosis.[7] This patient could not go out of the house because of the tormenting obsessional fear that he would commit murder. In this case the obsessional fear represented displaced and consciously denied murderous impulses toward his overly strict father. He said in effect, "Anyone capable of wishing to push his own father from a mountaintop into an abyss cannot be trusted to spare the lives of persons less closely related to him; he therefore does well to lock himself into his room."

COMPULSIVE RITUALS

As noted earlier, obsessive thoughts include also doubts, wishes, fears, impulses of various kinds, admonitions, and commands. Although it will not be possible to illustrate more of these at this time, a case of obsessive doubt will follow in the discussion of dynamics. The distinction between obsessive thoughts and compulsions is fairly clear. Stated simply by Cobb,[8] "When they lead to actions they become compulsive behavior."

Frequently compulsive behavior is repetitive or ritualistic. The child may explain his compulsive touching or avoidance on the basis that something evil or bad will befall if it's not carried out. He may say, "Step on a crack, break your grandma's back," "Step on a line, crush your mother's spine," etc. Spock[9] discusses the common appearance of mild compulsions around the ages of 8, 9 and 10 which are more likely to occur because "his conscience is just naturally becoming stricter at this stage of development." Kanner[6] and others have called attention to the frequency of children's games with ritualistic or compulsive rules.

The 9-year-old child's half-serious explanation that something unpleasant might occur is similar to the vague but stronger and more compelling foreboding and anxiety experienced by the adult who resists performance of a ritual or compulsion. There are many examples of compulsive rituals. The patient in case 3 often felt compelled to recheck his totals 3 times. The following case briefly illustrates a more severe "multiple-of-3" compulsion.[10]

Case 4. A 27-year-old veterinarian described the compulsion which required his flushing the toilet a multiple of 3 times whenever he entered a bathroom. Sometimes he was "satisfied" with 3 times only, but on other occasions 9, 27 or even more were needed. He was at a loss to control his compulsion, which had sometimes socially embarrassed him and was professionally handicapping.

The number of times required bore a relation to his current level of self-esteem and feelings of moral rightness. There were also certain deeper symbolic meanings tying back to earlier years and partly reflecting parental concerns.

Brill[11] and others have commented on the similarities and differences existing between religious ceremonials and neurotic compulsive rituals. The development of habits and patterns in living generally is a useful matter of psychic economy, convenience and great value to people generally. The extension of this into ceremonial rites for fraternal groups, military organizations, etc., not only serves the above purpose but appears to gain added meaning and significance. Undoubtedly, also, the repetition is familiar, reassuring, and both because of this and possible symbolism may serve to allay anxiety. Barker[12] in an interesting forthcoming paper discusses these aspects and others in relation to the long popular stereotyped Western Story. Masserman[13] has described stereotyped compulsive behavior observed as part of experimental animal neurosis.

In view of the importance of the conscience or superego in the genesis of obsessions and compulsions and the frequent incorporation of moral and religious precepts, it is not surprising that the content of neurotic thoughts and acts is sometimes related. In the following very severe case* the religious elements were developed as reënforcements to aid repression and control.

Case 5. A young married college graduate originally sought medical advice for dietary planning and constipation. He was found to be preoccupied about these aspects of his health, stating his fear that his intestines might become plugged or his stomach nonfunctional. How much water should he drink to avoid becoming dried out? These concerns, which rightly alarmed his physician, help, along with other severe elements in this case, to illustrate how close the severe obsessional can approach a psychotic state. This patient was very sick and suffered immensely.

Upon psychiatric consultation, he amplified these fears and told how desperately he dreaded the possibility of his wife becoming pregnant. If this happened, something incredibly bad would happen. On the rare occasions he allowed himself intercourse, every conceivable measure was used simultaneously to avoid such a dire possibility. He appeared rather pompous. His thought content was predominantly religious. "I must keep my mind on God all the time. It's the only Christian way of life." Anything else was sinful to him and he must not "drink, smoke, laugh, smile, or have angry thoughts. These are sinful. . . ." "The only way to be saved is to pray all the time. . . . There is a constant battle between God and Satan." (Actually, this for him is really the battle between the instincts he rejects as intolerably evil and the good, superego forces within himself.) It was even a sin to seek medical attention: "One should have trust in God to take care of health matters." He had restricted his diet gradually to exactly 1 tumbler of prune juice, 3 stalks of celery, 1 pint of ice cream, and 3 tablespoons of metamucil followed by 3 cups of water 2 times daily at stated hours.

Father was a worried, distant, rigid, and indecisive person also preoccupied with constipation and evidently obsessive-compulsive himself. Mother was moody, serious and subject to depressions in which she retreated to her bedroom for 2-day periods. Neither was able to provide affection, warmth, or acceptance. With such serious psychopathology as partly indicated one would be only justified in a pessimistic prognosis. Nevertheless, this patient made substantial progress during 6 months of a moderately intensive treatment régime. As objective physical indication of his improvement, his weight climbed from 145 pounds on September 20 to 156 by October 25 and to 167 on January 20. The red blood cells numbered 3,900,000 and his hemoglobin was 12.1 Gm. on September 15, increasing respectively to 4,850,000 and to 13.9 Gm. by January 22. This was in the absence of any drugs or dietary supplements, which he could have been induced to take only by absolute force. The physical changes represent the gradual surrender of stringent and desperate self-imposed dietary restrictions under the fortunately beneficial effects of competent psychotherapy.

This case serves to point out again the relation between bowel habits and personality. In one situation the patient pointed out direct changes in eliminative function and anger. He found himself particularly resentful and angry when an observer would appear while he was teaching. This was invariably followed by several days of constipation, a regressive response back to the now futile method of retaliation (by withholding) employed more successfully in infancy. In another instance of the important symbolic implications of bowel function and as one indication of his tremendously low level of self-esteem, this patient reported how he felt temporarily much better following a loose copious stool or flatulence, particularly when this was odoriferous. This meant to him symbolically the expulsion of part of his "bad self." He "thought" of himself as mostly bad, and the badness equated feces. This entered subconsciously into his urgent concern with maintaining elimination.

Another type of ritualistic behavior is not uncommonly seen in at least mild form in which some aspect of daily living becomes compulsively elaborated. In its most simple form this may involve the rechecking of the gas stove or lights. The following case illustrates a more extreme example[10]:

Case 6. A 40-year-old single business woman reported an involved compulsive ritual on retiring each evening. The stove was triple checked, windows and doors were carefully inspected, and a dresser was placed against her bedroom door. Finally, a long involved procedure had to be followed in exact fashion to get herself undressed, bathed and into bed. If an item were omitted, or perhaps not as it should be, it must be repeated or she could not sleep because of resulting anxiety. As in other instances, this type of ritualistic activity was a defense against anxiety. Investigation tended to confirm an early hypothesis that part of the ritual was an unconscious attempt to reënforce repression of her disowned sexual impulses. This patient was an unhappy inhibited person whose affectivity had been long frozen within herself. Efforts to interest her in treatment were unsuccessful.

(*To be continued*)

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* Reported to me by Boaz Harris, M.D.

President's Page

A VOLUNTARY CHRONIC DISEASE HOSPITAL

Of all the categories of health facilities required in the District of Columbia and environs the least accomplishment is shown in the provision of beds for chronic illness. In the District of Columbia mental and general hospital beds in existence and under construction now equal or exceed the requirements; tuberculosis beds equal 66 2/3 percent of the requirements; health centers 28.1 percent of the requirements; chronic disease beds exist only to the extent of 11.1 percent of the requirement, comprising the 182 beds in the Washington Home for Incurables, out of a necessary minimum need of 1,624.

The increased recognition of the prevalence of chronic and degenerative diseases only serves to point out the acuteness of this need, which has been so long recognized in the city. More favorable terms for Federal assistance in building a voluntary project for chronic diseases exist now than at any time in the past. Only for this category will the Federal Government contribute two-thirds of the cost to the District of Columbia under the Hill-Burton Act; it will contribute 50 percent under Public Law 221, 82nd Congress. A campaign raising two million dollars for such an institution would get four to four and a half million dollars total under these two laws. Where is there to be found a group of public-spirited citizens who will undertake to spearhead such a movement to build and operate a chronic disease hospital of 350 to 400 beds?

Herbert P. Ramsey

Editorials

SHOUTING IN THE DARK

There are many perplexing items of unfinished business on the medical public relations agenda today. For example—

Last August *Reader's Digest* published an article entitled "Hysterectomy: Medical Necessity or Surgical Racket?" This article, read by millions of people and widely quoted in other publications, severely indicted the medical profession for performing too much unnecessary female surgery.

What formed the basis for such a negative article?

A careful analysis shows that the author lifted material out of context from six different medical publications, including two studies reported in *The Journal of the American Medical Association*.

This proves an often-overlooked fact in medical public relations: that articles written by physicians and published in medical journals for the enlightenment and educational benefit of their colleagues can be picked up by lay writers and twisted into a more or less sensational story for lay readers. It appears today that what a doctor writes, frankly and objectively for the betterment of his profession or the advancement of medical science, can actually boomerang to the detriment of the profession as a whole.

Let us analyze the facts.

The *Digest* article strongly implied that doctors were too hasty with a knife when it comes to treating women patients.

The *Digest* writer quoted 135 words from an article by Dr. James C. Doyle of the University of California, which appeared in the March 29, 1952 issue of the A.M.A. *Journal*. Dr. Doyle's article ran several thousand words. It is true that he called attention to "the unwarranted sacrifice of normal ovaries." The original article had much more to it than the blunt statement that doctors were performing too many hysterectomies. But, many of the explanatory statements, intended to teach doctors and thereby correct a problem for the benefit of all women patients, were never referred to in the *Digest* article. The lay reader saw only the negative side. He never saw the positive conclusions, such as the following, which were aimed at teaching the medical profession.

"Many hospital administrators, clinicians and pathologists," Dr. Doyle said, "are concerned about unnecessary operations. The particular concern of this paper is the unwarranted sacrifice of normal ovaries. . . . Countless articles have been appearing relating to lesions of the ovary, their nature, their incidence and the removal of normal ovaries. Reports of large numbers of such cases have been found."

And another statement by Dr. Doyle, which follows, conveys an honest effort on his part to present a problem to practicing physicians—a problem which he believed warrants correction:

"The women of America seek reassurance primarily in regard to cancer, real or imaginary. The light of public opinion shines brightly today on the achievements of medical science. There is especial interest in gynecologic operations. . . . Our patients' faith and trust will be justified so long as we are professionally and intellectually honest with both them and ourselves. It is but a decade or two ago that patients visited the physician only as a last resort, and frequently in the terminal stages of the disease. Today, more and

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia.

more patients seek examination periodically. The periodic examination is futile unless incipient conditions are detected early and the proper therapy is recommended promptly when a correct diagnosis has been made. The responsibility to their patients in this regard is exceedingly great for both the general practitioner and the general surgeon, who are consulted earlier and oftener than the specialist."

Dr. Doyle supported these statements with unvarnished statistical facts. He, like other doctors who write scientific articles, feels that the medical profession must exist as a family, each member contributing to the welfare of all, so that gaps are bridged.

The *Digest* used only 200 words from another article in the July 23, 1949 issue of the A.M.A. *Journal*. It was written by the late Dr. Robert T. Frank of New York, who discussed some 916 fibroid cases, which, the *Digest* said, were "picked at random from records of his 50 years of practice."

"Only five cases required emergency surgery," the *Digest* article added, "and in only two of these was the emergency attributable to fibroids alone."

Like Dr. Doyle, Dr. Frank wrote his article for the doctor, not the layman. His information, gleaned from 50 years of "seeing, examining and advising women who are sick or believe themselves to be sick," was published solely for the enlightenment and teaching of other physicians. But since some of his material was taken out of context millions of lay readers couldn't help get the wrong impression.

Dr. Frank was speaking as a teacher when he said:

"The health, happiness and future morale of many a patient (female) will rest on the tact, insight and kindliness with which the attending physician, most often the general practitioner—the family doctor—enlightens her about the presence of a fibroid of the uterus. If his knowledge and experience do not qualify him to give a decisive verdict, he should at least offer reassurance and request a qualified opinion from a specialist. Unless this precaution is observed, it makes future treatment difficult or impossible, unless it coincides with the first opinion voiced, which may well have been faulty. Selection of therapy, if such be needed, should be done only after consultation and discussion with a competent gynecologist."

No such qualifying statements ever appeared in the *Digest* piece, which, actually, was unfair to Dr. Frank.

If the good Lord Himself were to direct medicine's public relations I doubt if there is anything He could do about correcting the problem of lifting material out of context from medical publications and using it for dissemination to lay readers. An important point to remember is that writers for so-called lay publications work for an institution or business whose freedom is guaranteed under the Constitution of the United States and all of the state constitutions. As long as a lay publication gives credit to the journal quoted there is little that can be done in a corrective way.

If doctors tried to bring about a change by telling a lay writer what he can and cannot write they would find themselves shouting in the dark.

It is a sad commentary on present-day writing, but reader interest in medical science is so great today that it is almost impossible to keep all of the material within the bounds of good taste from the standpoint of the profession.

If doctors, as a profession, do not endeavor to correct a specific situation they find themselves damned. And if they try to correct a situation through medical writing and reporting, as has been done in connection with female surgery, they are damned, too. Possibly, this is all due to the fact that medicine is the most human of the sciences. One might call it the science of man, for among all the numerous seekers of knowledge, medical investigators—and that includes the doctors—have been the most consistent, the most objective, and the most successful in their persevering study of the human being.

The time has come for physicians, writing about research at the bedside, the operating table or the laboratory bench, to give thought to more cautious use of words in the articles they pen for medical journals. Words should be governed by principles of good taste and good use. A physician's expression often is shocking if taken literally. Laymen are prone to misunderstand. Consequently physicians must weigh their words for exact meaning, keeping in mind how the words they use will sound outside the profession.

John L. Bach
Director, Press Relations,
American Medical Association

EVALUATION OF CLINICAL LABORATORY SERVICE

The physician's reputation is based in no small measure upon the quality of his professional assistants. Of all physicians, the pathologist is perhaps most vulnerable in this regard. Usually he is responsible for the work of a large number of individuals. A slight slip by any of them may result in a serious mistake. The faulty identification of a specimen, the misplacing of a decimal in a calculation, the contamination of a reagent—any one of a hundred small things may introduce error.

The pathologist must continually search out all sources of error. He must select his technologists carefully, with particular attention to professional competence and personal integrity. He must appraise their results critically and at frequent intervals. He must provide the opportunity for their continual self-improvement.

The clinical pathologists of the Washington area have done more than most professional groups in developing the technic of self-appraisal. Through the Section on Pathology and Laboratory Medicine of the Medical Society of the District of Columbia local pathologists are now completing their second year of critical self-evaluation. This has been done entirely on their own initiative, without coercion by any governmental or private agency.

Possibly the initial incentive for these evaluation studies was received from members of the corresponding organization of pathologists in Virginia. This group arranged with Dr. F. William Sunderman, of Jefferson Medical College, to receive regularly, at cost, beginning in 1951, sealed ampules containing carefully calculated quantities of various chemical substances. Dr. Sunderman, a former president of the American Society of Clinical Pathologists and a master of medical chemistry, supplied a set of unknowns, e.g., calcium solutions, each month, varying the substances to be tested from month to month. He kindly expanded this program to include those Washington pathologists who wished to participate. Dr. Sunderman's evaluation studies are still in progress and cover most procedures in clinical chemistry.

Stimulated by these studies, and fully aware of their value, the Washington group inaugurated its own program in the fall of 1952. Various members of the Section volunteered to serve as referees in fields in which they had special interest or special competence.

The first study was in prothrombin determinations. Each hospital received a group of unknown bloods to be tested. On a score sheet each pathologist entered his results on the various samples, and also listed the source of thromboplastin and other testing materials, method of reporting, etc. These score sheets were returned to the referee, who tabulated the results. His findings were presented at the following meeting of the Section, and comprised the feature of the scientific program. It became obvious that some standardization in the method of reporting was desirable in order to avoid confusion. Modifications were adopted by the Section, and a uniform system of reporting "prothrombin activity" came into being among the laboratories in the Washington area.

Since that time the following surveys have also been made: hemoglobin and hematocrit determination; Rh antibodies; total blood proteins, albumin and globulin; identification of bacterial cultures; agglutination tests; serologic tests for syphilis; blood smears and stools for parasitologic studies. In each instance the survey has formed the basis for a critical evaluation of methods, materials, and other factors, and has been presented at the following meeting of the Section. Often a disinterested expert has served as special referee, or has been brought in for advice on limited aspects.

In order to bring directly to the technologists the results of these studies, the Section offered to present substantially the same program to the District of Columbia Society of Medical Technologists. This material has been presented at their regular monthly meetings and at their annual seminar.

As a result of these studies many things have been learned. Certain tests, acceptable for years, have been shown to have a wide margin of error even under controlled conditions. Apparatus and reagents have been evaluated critically. Uniformity of terminology has been adopted in certain fields.

The pathologists believe that these studies have contributed significantly to the improvement of laboratory service in the area. They will continue their efforts in these fields.

No profession or specialty is so perfect that it cannot profit immensely by friendly, impersonal self-appraisal.

T. M. P.

A NIGHTMARE

The other night, in place of restful slumber, I had a dream. After counting the usual quota of sheep, sleep of a sort came, and during this restless sleep, a nightmare.

Somehow, in the peculiar mixed-up ways that dreams have, I was in court. I was both an observer and a defendant, and at times even seemed to be a witness. The judge, an unreal and awe-inspiring figure, called three physicians as defendants to take the stand.

The first was a physician who was specifically accused of sending a large bill to a patient in very moderate circumstances, and for a service which was not unusual in any way. This defendant admitted that he had not determined the patient's ability to pay "because he didn't feel it was fitting for a physician to discuss money matters." Further, he argued, there was the probability that an insurance company was paying part or all of the bill, so "because an impersonal agency was responsible, he was justified in charging a large fee." In my dream I recall being very disturbed because neither the judge nor the jury, as laymen, seemed impressed by the defendant's reasoning.

The second defendant was another physician, not overly impressed with his own importance, but hurried and harried in his manner. He was accused of rendering substandard care, inadequate examinations, both clinical and laboratory, and shotgun therapy. When he explained that he was too busy to do careful work, the court again did not seem impressed. The only comment came from the judge, who suggested that possibly more help was needed in the medical profession.

The third defendant was another physician. The man's manner was arrogant and impersonal. He was specifically accused of failing to discuss anything with his patients, either medical or financial. Several witnesses declared that the physician was reluctant to tell them what was wrong, what significance their medical condition had for them, and what their financial obligation probably would be. His attitude was that they were fortunate to be able to retain his services without wasting his time with useless explanation. Again, surprisingly, the court did not seem favorably impressed by the defendant's testimony.

Having heard these three defendants and numerous witnesses, the judge gave his instructions to the jury. He was in the midst of telling them that they must consider fairly the evidence for and against these three medical men, and at the same time decide whether this evidence reflected favorably or unfavorably on the practice of medicine as a whole and the conduct of "organized medicine." Fortunately, at this moment a final witness asked to be heard and this unusual privilege was granted. In his testimony he pointed out that thousands of physicians were practicing honestly, intelligently, and thoughtfully, and that American medicine was a leader in the field of world medicine. He urged that the medical profession not be condemned for the thoughtless, selfish tactics of a few of its members.

This testimony very obviously impressed both the judge and the jury, to the extent that further instructions were given the jury. In these instructions the judge pointed out that the whole medical profession shouldn't be condemned for the acts of a few. He did, however, emphasize the responsibility of "organized medicine" to keep its house in order, to instruct and discipline its recalcitrant members, and to be a leader in providing the best medical care at a price the public can pay. He pointed out that the possible alternative would be Government-sponsored and -regulated medical care.

At this point I awoke in a cold sweat, thanking my stars that this was only a dream ...... or was it?

F. D. C.

ARLINGTON COUNTY'S PROGRAM FOR CRIPPLED CHILDREN

The clinic for crippled children in Arlington County is an excellent example of what can be accomplished in the field of public health and preventive medicine when all official and unofficial agencies coördinate their efforts. The groups which have made a success of this undertaking in Arlington are the U. S. Children's Bureau, the Virginia State Department of Health, the local chapter of the National Foundation for Infantile Paralysis, the Virginia Society for Crippled Children and Handicapped Adults, the State Anti-Convulsive Board, and the local Health Department. The program has always received excellent coöperation from the practicing physician and the local medical society.

The clinic had its inception about 20 years ago when the late Dr. Donald Faulkner, an orthopedic surgeon of Richmond, coöperating with the Health Department staff locally, conducted an orthopedic clinic twice annually. Ten years later Dr. O. Anderson Engh and his staff held clinics monthly. Later, clinics were held weekly; at present they are conducted each Tuesday and Thursday.

The area served by this clinic includes the counties of Arlington, Fairfax, Fauquier, Prince William and the cities of Falls Church and Alexandria. A limited number of cases are accepted from other nearby counties.

In January, 1953 the new clinic building for crippled children was opened on North Edison Street adjacent to the Health Department. This is one of the most modern and up-to-date structures of its kind in the Nation. It was built with Hill-Burton and local and state funds through the School Board.

In the new building is housed the Edison School, operated by the School Board for such children who are so severely crippled as to be unable to attend the regular schools. These children are screened before admission by the school physician, psychologist, and speech and hearing diagnosticians.

An occupational therapy treatment service is attached to the school, as well as a speech therapist. Children are transported to the school by school buses, given a hot lunch and an hour's rest on portable cots in the middle of the day. The staff consists of 2 teachers, an occupational therapist, and a part-time hearing and speech technician.

Patients are referred to the clinic by physicians, social workers, nurses, health departments, school authorities, welfare departments, private health agencies, and others. The clinic is a part of the county Public Health Department and is under the general supervision of the Director of Public Health, Dr. R. G. Beachley. Clinics are conducted each Tuesday and Thursday by the Chief Clinician, Dr. O. Anderson Engh, and his staff. A pediatrician is present at the clinic sessions. The full-time clinic staff consists of a supervisory orthopedic nurse, 2 physical therapists, 2 clerks, 1 public health nurse, and a maid. Adjoining counties assign a public health nurse to assist on clinic days. A report of the findings on each child, as well as the progress of the case, is forwarded to the attending family physician.

Children needing hospitalization are sent to the Arlington Anderson Orthopedic Hospital locally. A few are sent to the Crippled Children's Hospital in Richmond, the Medical College of Virginia, or the University Hospital in Charlottesville.

At the age of 15 children with major orthopedic conditions are routinely referred to the rehabilitation supervisor for the Northern Virginia area. This service is furnished by the State Board of Education. Guidance, vocational training and selective placement are three of the major services provided in this field. The furnishing of appliances, braces, and corrective shoes is provided on the basis of financial need.

The Guidance Center's services in the Health Department are at all times available to the crippled children's program. All referrals to the clinic receive a psychological examination which includes a psychometric evaluation.

Monthly case conferences are conducted, at which time nurses, physicians, physical therapists, and others interested discuss certain cases and talk over ways and means of improving the program.

In addition to the foregoing and as a part of the crippled children's services, the local Health Department, coöperating with the State Anti-Convulsive Board and the Virginia Society for Crippled Children and Adults, conducts quarterly a clinic for children with convulsive disorders in the Northern Virginia area. This service is staffed by neurologists from the U. S. Public Health Service, the University of Virginia, and locally. Approximately 40 children are seen at each clinic. The referrals are made chiefly by physicians. A report is sent to the attending family physician. Hospitalization is arranged for when needed. Both adults and children are admitted to the Anti-Convulsive service.

The Arlington County program for crippled children, which began in 1934, has been most satisfactory and rewarding. All agencies concerned have pooled their efforts to the end that it has evolved into one of the most efficient services for crippled children to be found in the country. Many public health officials from other states and foreign countries visit the clinic annually. There are about 600 children registered from the Northern Virginia area in the clinic, and approximately 200 are registered in the Anti-Convulsive service. Needless to say, the restoring of the crippled child to even partial use of an afflicted limb or part of the body is one of the most rewarding activities in which a community can engage. This program has had for many years the undivided support of all concerned in Arlington.

H. P. R.

In and Out of Focus

BY THE OBSERVER

"A Fortress of Conviction—"

Both Blue Shield and Blue Cross Plans have noted what one Blue Shield official described as a slackening of the "Blue Shield enrollment growth rate, nationally, and more rapid growth of business on the part of commercial carriers"; that, in a number of instances, commercial companies have been guilty of semi-plagiarism of the name "Blue Shield" which has "beyond doubt" led to confusion in the public mind and to what he describes as "a tendency to think of Blue Shield as 'just another insurance company.' "

In view of this and other developments, the Plans have embarked upon "a national program of public education," under the direction of the Joint Executive Committee of the Blue Cross and Blue Shield Commissions, to bring home to the public the unique role played by Blue Cross and Blue Shield in the prepayment of medical and hospital care.

As R. M. Jones, Director of Blue Cross Commission, explains it, "Blue Cross Plans are agencies of the Nation's community hospitals. We are the only Plans for health care with that distinction. We're proud of that, and we think the public needs to know that when they enroll in Blue Cross, they will receive benefits that hospitals themselves render through formal agreements with 6,000 hospitals in the United States and Canada."

As to the value of the educational program, he says, "A fortress of conviction can be built in readers' minds to help them properly evaluate the welter of promises being made today in the hospital and medical protection marketplace."

Frank E. Smith, Director of the Blue Shield Medical Plans, points up the fact that "the 77 Blue Shield Plans throughout the country and its territories are endorsed by medical societies in their various localities. Each of them attempts to meet the medical needs in the area it serves."

Referring to imitators of the Blue Shield Plans, Mr. Smith states, "To be imitated is a sign of superiority, but when imitations begin to confuse and misdirect, then clarification is necessary."

Up to date, both Blue Cross and Blue Shield Plans have refrained from advertising in a commercial sense. The present program, financed by 84 Blue Cross Plans and 77 Blue Shield Plans, will call to the attention of the readers of *Life*, *Look*, and the *Saturday Evening Post* the story of the "typical American growth in a voluntary community enterprise."

★

CD a Delusion?

Anyone looking through the files of the MEDICAL ANNALS will find editorial comments on the Civil Defense medical program with such captions as: "CD Begins to Roll" (February, 1951); "CD Stalls" (May, 1951); "Civil Defense Fades" (October, 1951); and finally "CD Still in Doldrums" (April, 1953).

Following these last observations, there appeared to be no occasion for further comments until there was evidence that the apathy which had all but extinguished the CD medical program had been overcome.

Without warning, the explosion of the H-bomb in March, 1954, became headline news. It was then that your Observer found himself wondering what had happened to the District's CD medical program. He thereupon called a local CD medical official and learned that some progress had been made. Among the accomplishments mentioned were the establishment of a complete hospital unit and 40 casualty stations with the supplies necessary in the event of disaster; the organization of a first-aid training program in Catholic High Schools for workers required by casualty stations; the appointment of a staff of 14 physicians, some of whom had been assigned as medical directors of zones into which the city has been divided; and the completion of regulations governing the conduct of the medical program in the event of disaster.

The official made no bones about the fact that in the light of the H-bomb the present CD medical program was outdated and that perhaps the apathy which had so long frustrated CD officials had served a useful purpose. Your Observer agreed, directing his attention to the statement of Louis L. Strauss, Chairman of the Atomic Energy Commission, that the present H-bomb could be made large enough to knock out any city in the world. Mr. Strauss was asked by reporters if he meant a city like New York and he answered in the affirmative. He hastened to explain that by "knock out" he did not mean it would be leveled but, as he said, "put a city out of commission."

Further details made public revealed that in a recent test an island in the Pacific disappeared under the impact of the explosion, leaving a crater 175 feet deep; that the first H-bomb was 250 times more powerful than the A-bomb dropped on Hiroshima; and the one detonated in March of this year was three times more powerful than the original.

When one considers these facts, how effective are the present CD plans? One Congressman, Chet Holifield of California, a member of the Joint Committee on Atomic Energy, was quoted as saying, "Civil defense against a hydrogen bomb attack is a delusion."

Undoubtedly, if history repeats itself, a defense against the H-bomb will eventually be discovered; however, this possibility seems very slight at the present moment. If the continuance of the present CD medical program is not justified, how can it be modified to cope in some degree with a situation which may conceivably exist? That, of course, is for experts to determine. Nevertheless, it seems quite evident that dispersal of medical facilities is of paramount importance. At the same time it would seem that abandonment of an adequate medical program in urban centers is unjustified. For example, if Washington were to become a target there is always the possibility that the enemy would fail to make a direct hit. In this event, all medical resources available would be needed. On the other hand, if the enemy should find the target, adequate facilities at some distance would be imperative for those who survived the blast.

Evacuation of the well and the ailing is another problem of deep concern to CD officials. It is, perhaps, the most challenging of all and one for which there is, apparently, no immediate solution.

All this, to put it mildly, is not pleasant to contemplate, but these are possibilities which those in positions of responsibility cannot ignore.

It would seem that the apathy which has so long plagued the CD medical program will no longer impede its progress, for the H-bomb appears to be the ultimate in destructive weapons.

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Presidential Sneeze Is News

President Eisenhower, like his predecessors, has found it difficult to accept public concern for his health and, as one writer puts it, that "a Presidential sneeze is news." Recently he is quoted as saying to a friend, "I'm not complaining, mind you. I just never thought people would be so interested in me. My gosh, I can't even have a bellyache in private."

The fact is, of course, that the President's slightest indisposition is not only news but fuel for countless second-guessers who are often the authors of some pretty disquieting rumors. While this has always been so, there are apparently more otherwise sensible people giving credence to unverified reports than in many years. This can undoubtedly be accounted for by their acute recollection that, despite the wan appearance of the then rapidly failing Franklin D. Roosevelt, his physicians insisted that he was in good physical condition up to the day of his death.

If appearances are any indication, the President bears out the statement of his doctor, Howard McC. Snyder, that he is in vigorous health. Apparently with the view of quelling unfounded rumors, Dr. Snyder permitted himself to be interviewed by Andrew Tully, Scripps-Howard staff writer, who, in *The Washington Daily News* for February 26, writes:

> "Dr. Snyder, without hesitation, calls President Eisenhower 'one of the soundest persons, physically, I have ever examined. He shows far less wear and tear than you would expect when you consider his burdens of office. His health is well above average for a man of his years (63). I'm not worried about him at all.'
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> "Reassuring words, these, and Dr. Snyder offers practical proof to back them up. These are the results of various examinations the President has undergone during the past year, and which are repeated about every three months.
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> "First, there is the matter of blood pressure. The President averages 140/86, which Dr. Snyder says is a 'good dynamic blood pressure—it should be about that for a dynamic individual like the President.' Moreover, his blood pressure has varied little over the years. It has on a few occasions been as high as 156/96 but this always has been lowered by short periods of rest.
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> "The President's pulse rate averages 72 beats per minute. This rises to between 92 and 96 after exercise, and returns to 72–74 within two minutes after exercise is stopped. 'It shows the man is in pretty good shape when his pulse goes back to normal so quickly,' says Dr. Snyder.
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> "Mr. Eisenhower was subjected to his last electrocardiogram in August, 1953, while on vacation in Denver. This test, which produces a graph of the electrical effects produced by heart contraction, showed no abnormalities. There have been no symptoms of any cardiovascular disease, such as shortness of breath on exertion.
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> "A chest X-ray also was taken last August, with negative effects.
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> "Likewise, no abnormalities were found when the President was X-rayed for gastrointestinal diseases and for gallbladder trouble. Several full blood counts and urinalyses and four analyses of the President's blood chemistry have been made in the last year; all the results have been normal.
>
> "Aside from a couple of colds, the President's only illnesses since he assumed office were two attacks of what is called intestinal flu—'acute gastroenteritis' in medical language."

Mr. Tully then reviews his previous "medical history" which reveals that, on the whole, his ailments have been of a minor nature; that he has had his appendix and tonsils removed; that he suffered a knee injury during his football days at West Point which still bothers him; and that the bursitis which afflicted him in Denver last year is much improved.

One can sympathize with the Chief Executive in his desire for privacy, but this, as he now knows, is not possible, particularly when so much depends on his vigor, both physical and mental. Even a man in the best of health is, at 63, no longer young. The heavy burdens of the Presidency have left their mark on the sturdiest physiques, and, of course, President Eisenhower will not escape unscathed. That is all the more reason for the close medical supervision given him by Dr. Snyder, who is not only keeping close tab on his physical condition but is insisting that he seek relaxation suitable to his age whenever his duties permit.

It is difficult to understand why some of his critics begrudge the President his golf and fishing. It appears to this observer that the country would be better served if he did more of both.

★

Honorary Members Our Medical Society is deeply indebted to the late Dr. John B. Nichols for much of the knowledge it has of its past. Tireless in his search for old documents and other historic material, he saw to it that they were preserved for those who, like himself, found pleasure and inspiration in acquainting themselves with their predecessors, their problems and their activities.

The Society owes Dr. Nichols a special debt of gratitude for the excellent history* he completed just a decade ago. It represented months of patient and unremitting labor and will remain a lasting monument to his devotion to the Society of which he was once President.

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* History of the Medical Society of the District of Columbia, Volume II, 1833–1944.

Dr. D. S. Lamb was the author of Volume I of the History, 1807–1909.

There was not as much duplication of information in these histories as one would expect although they covered, in large part, the same period. Dr. Lamb's volume was written in narrative style and did not contain the detailed data which Dr. Nichols considered important. Consequently, where there is any duplication, Dr. Nichols' history is the more valuable as a reliable source of information.

In looking through this volume recently, your Observer's attention was attracted to the list of Honorary members, the first of whom was elected in 1819. He felt certain that many members were unaware of the eminence of some of these physicians and their important role in medical history. It was this which prompted these comments.

While qualifications for Honorary membership have undoubtedly changed over the years, the fundamental requirements cannot have varied greatly. The present Constitution and By-laws provides that "Any physician, scientist, or other person who deserves recognition, by reason of eminent contributions to medical or collateral science or of meritorious services to the medical profession, may be proposed for honorary membership. . . ." There follows the procedure to be followed in proposing and electing such members.

As might be expected, the names of those singled out for recognition in the early years of the Society mean little to present-day physicians. For example, Dr. Wm. Beans, of Upper Marlborough, Maryland, was the first physician to be elected an Honorary member. The year was 1819, the one in which the Society received its charter from Congress. Who was Dr. Beans? The only mention of him in Dr. Lamb's history is in the biographical sketch of Dr. Thomas Clagett Scott (1784–1837), who, it is stated, studied under Dr. Beans. No mention is made of Dr. Beans in Dr. Nichols' history other than his inclusion in the membership roster. However, he must have been highly thought of by his fellow practitioners.

Of the 71 Honorary members elected since 1819 most, like Dr. Beans, have faded into obscurity. But there are a number, as previously stated, whose names will always have an important place in medical history. Among them are:

Philip Syng Physick (1768–1837). "Father of American Surgery," elected in 1821.

John Shaw Billings (1838–1913). Largely responsible for the development of the Army Medical Library (now Armed Forces Medical Library) into the finest institution of its kind in the world. Elected in 1875.

Sir William Osler (1849–1919). Osler addressed the Medical Society on May 1, 1895, at which time he was elected.

Abraham Jacobi (1830–1919). Founder of the pediatric specialty. Elected in 1900.

William W. Keen (1837–1932). Famed surgeon. Assisted in operation on President Cleveland for cancer. Maternal grandfather of Dr. Walter Freeman of Washington, D. C. Elected in 1905.

George Martin Kober (1850–1931). Eminent physician, medical educator, and philanthropist. One of the Society's most outstanding members. Elected in 1931.

There are, of course, others on the list who belong in this select company but these are the most familiar to your Observer. He noted with interest that outnumbering all others were physicians who had attained prominence in the military services. The following are the various branches in which they served, and their names:

Surgeons General of the Army: Joseph K. Barnes, elected 1866; Charles Henry Crane, elected 1875; George Miller Sternberg, elected 1895; James Rufus Tryon, elected 1895; William Crawford Gorgas, elected 1915; Merritte Weber Ireland, elected 1929; James Carre Magee, elected 1943; Norman T. Kirk, elected 1944; Raymond W. Bliss, elected 1948; and George E. Armstrong, elected 1952.

Surgeons General of the Navy: William Maxwell Wood, elected 1874; William Clarence Braisted, elected 1916; Ross T. McIntire, elected 1943; Clifford A. Swanson, elected 1947; and Lamont Pugh, elected 1951.

Surgeon of the Air Force: David N. W. Grant, elected 1944.

Surgeon General of the Air Force: Harry G. Armstrong, elected 1952.

Assistant Surgeon General of the Army: James Mann, elected 1819.

Surgeons of the Army: Joseph Janvier Woodward, elected 1874; John Shaw Billings, elected 1875; and George Alexander Otis, elected 1875.

Medical Director, Selective Service System: Leonard G. Rowntree, elected 1946.

Army Medical Library: Robert Fletcher, elected 1896.

Other categories in the Government service and those honored have been:

Department of Defense: Richard L. Meiling, elected 1950, and Melvin A. Casberg, elected 1953.

Surgeons General of the U. S. Public Health Service: Walter Wyman, elected 1895; Rupert Blue, elected 1916; Thomas Parran, elected 1943; and Leonard A. Scheele, elected 1948.

Personal Physicians to the President of the United States: Wallace H. Graham, elected 1946; and Howard McC. Snyder, elected 1953.

Your Observer is certain his readers will agree that these, and others who are undoubtedly equally deserving of mention, make up an imposing array of medical talent which reflects great credit upon those responsible for their selection as Honorary members of the Society.

★

Other Pastures— It is the rare physician indeed whose peace of mind is not disturbed by unreasonable patients. Sometimes he is quite overwhelmed by their inexplicable behavior and, in his low moments, is certain that members of no other profession are so sorely tried.

It seems, however, that dentists too have their problems. Some days before he sat down to "sweat out" this column your Observer received tear sheets from *Oral Hygiene* for March, 1954, containing an editorial entitled "The Stresses We Live Under" by Dr. Edward J. Ryan. Dr. Ryan describes the "hard life" of his fellow dentists, in part, as follows:

> "The dentist spends his working day doing things to people that they do not like and do not enjoy paying to have done. It is a stressful situation to the patient and to the dentist. After a 30- or 60-minute appointment, the patient is on his way again to return to things that he considers to be more pleasurable. The dentist, however, must continue hour in and hour out, week after week, year upon year, to listen to the complaints and to react to the attitudes and the behavior of his patients. It is a hard life.
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> "In the acutely painful situation the person in pain reacts as a total personality. The actual painful stimulus may be in the tooth but the reaction involves virtually every tissue of the body. Some people are hyper-reacters and their responses are overwhelming. They groan or cry or grimace; they contract their muscles and distort their faces. Many of them during this experience are accusative in word, and many more are probably violently accusative in their thoughts. Although the patient is experiencing the direct reaction, the dentist, unless he is a case-hardened sadist, is participating in the event. It is taking something out of him as well as it is out of the patient. Anxiety among dentists and some of their functional and organic diseases are very likely initiated by their patients.
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> "Many people by devious processes of reasoning blame us for their dental disease. The question, 'Just why do my teeth decay so much?' is more than a rhetorical one. It carries the undertone, often poorly disguised, that the dentist somehow is responsible for the condition. The patient who says, 'One of *your* fillings came out,' is placing the blame directly on the dentist, regardless of whether or not the dentist placed the restoration. The same person in referring to a breakdown in his automobile or his household appliances uses the expression *my*. There is a subtle difference in the attitude that he has toward his dental tissues, their diseases and treatment, and the attitude that he holds toward his material possessions.
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> "People also 'blame' us for hurting too much and for charging too much. Actually, the constant development of analgesics and anesthetics, of instruments of new materials and design, is testimony that one of the major activities of the dental profession is directed toward pain control. Fortunately for us, there are patients who appreciate these advancements and are generous in expressing their appreciation of them.
>
> "On the subject of fees there is no end to discussion, usually unfavorable to the dentist. As a general statement it might be said that dental fees have not kept pace with the increases in the costs of living. We may argue in full truth, but without the power of conviction, that dental care improves health, comfort, and appearance. These values are unmistakably true but people will continue to complain and to blame."

The editorial ends on this pessimistic note:

"It would be well if studies were made on stresses and diseases as they affect dentists as well as their patients. The high morbidity and mortality rates among dentists and physicians for some forms of disease suggest that their work may predispose them to certain types of stress diseases."

Other pastures may look greener, but—

"In and Out of Focus" will not appear in the June, July and August issues of MEDICAL ANNALS. It will be resumed with the September number.

T. W.

NEW REGULATIONS FOR MATERNITY AND NEWBORN HOSPITAL CARE

Regulations governing maternity and newborn care in hospitals of the District of Columbia under the Hospital Licensing Act of April 20, 1908 were approved recently by the Board of Commissioners and will become effective, June 1, 1954.

Although copies of the code are available to anyone, some of the background of how these regulations were arrived at and highlights of their content may be of interest at this time to those who care for maternity and newborn patients.

Under the Hospital Licensing Act of 1908 no special provisions were made relating to the care of the mother and her newborn infant. The Department of Public Health had been working on regulations pertaining to this field since 1938, and in 1940 the Corporation Counsel turned down proposed rules and regulations on the basis that they were too vague and ineffective. Following that experience, work on regulations continued, but because of lack of staff and World War II conditions, very little was accomplished. Some instances of maternal and neonatal deaths occurred during the early 1940's, and through the combined activity of the Department of Public Health and interested lay groups in the community, Congress, under the Appropriations Act of 1949, provided funds which permitted the Bureau of Maternal and Child Health to employ a full-time physician to investigate the problem. In 1951 a study was made of prenatal clinic care and maternity and newborn care in the hospitals of the District of Columbia. Based on the findings of this study, a body of rules and regulations, having the force of law, was formulated by the Department of Public Health to govern the operation and conduct of hospital and maternity departments toward the end of achieving a higher quality of hospital care.

The proposed regulations as first promulgated were distributed just prior to a public hearing originally set for October 19, 1953. They contained many features to which groups within the Medical Society of the District of Columbia took vehement exception. The President of the Medical Society called a meeting of individuals representing various groups which would be most affected by these regulations. Following this initial meeting a special committee was designated, consisting of physicians in the specialties, obstetrics and pediatrics, and representatives of the hospital administration and nursing fields. This committee was charged with the responsibility of reviewing the proposed regulations with representatives of the Department of Public Health so as to arrive at a modified version which would be acceptable to the groups concerned and the Department of Public Health.

After numerous meetings, consuming many hours, with representatives of the D. C. Department of Public Health, the committee agreed on a revised version which was in general acceptable to all groups. Conferences with the legal counsel of the Medical Society of D. C. and the D. C. Department of Public Health, in conjunction with the Acting Director of Public Health and the President of the Medical Society, achieved further modification. The new version was presented to the Board of Commissioners at a public hearing on January 18, 1954. Following this hearing still further amendments were made and in their final form the rules and regulations relating to maternity and newborn care in hospitals were finally approved and will become effective on June 1, 1954.

Provision is made that these regulations be reviewed at least every five years by the Director of Public Health, with appropriate advisory groups, with a view to recommending to the Commissioners such revisions as are agreed upon and as are in the public interest. Such advisory groups should include representatives of medical, hospital, and nursing organizations.

Some of the salient features of the new regulations follow:

Scope. The provisions of the regulations apply to any hospital licensed as such by the Government of the District of Columbia, or part thereof used to provide maternity or newborn hospital care on an inpatient basis. (Note: Under the existing Hospital Act these regulations apply only to the voluntary hospitals. The D. C. General Hospital would not come under these provisions unless included by order of the Commissioners. Hospitals operated in the District of Columbia under Federal auspices would also not be affected.)

Permit requirements. Any hospital used to provide maternity and newborn care must apply to the Commissioners for a permit to provide such care. Provisional permits on an annual basis up to a maximum of five consecutive years may be issued to any hospital unable to conform to all the provisions of these regulations. The Commissioners may suspend or revoke such permit or provisional permit whenever it appears that any hospital maternity department is conducted contrary to the provisions of the regulations except when such conduct may be caused by an emergency.

Accommodations and equipment. The maternity department shall be maintained as a separate service and only maternity and newborn infants hospitalized in the maternity department. The anesthesia, clinical and pathologic laboratory and X-ray work shall be under the direction of persons specially trained, and personnel shall be present or on call to provide these services.

In existing maternity patient rooms the minimum floor area per patient unit shall be 80 square feet in single-bed rooms and 70 square feet in multiple-bed rooms. In hospitals constructed after June 1, 1954, the minimum floor area shall be 100 square feet in single-bed rooms and 80 square feet in multiple-bed rooms. Individual bedside and other personal equipment is stipulated.

Auxiliary facilities are also provided for, particularly in the area of sanitary precautions as safeguards to patient care.

Delivery rooms shall be provided in the ratio of at least 1 delivery room for every 20 beds in maternity patient rooms and shall not be used for any purpose other than that pertaining to the maternity patient or her infant. Necessary facilities, equipment and supplies for the delivery room and delivery unit are set forth.

The newborn units shall include patient accommodations for (1) a full-term newborn unit which shall house not more than 12 bassinets per nursery (In existing hospitals there shall be at least 20 square feet of floor area for each bassinet. Hospitals constructed after June 1, 1954 must allow not less than 24 square feet of floor area for each bassinet.); (2) a premature newborn unit in maternity departments of 20 or more beds; (3) a suspect or observation newborn unit which shall house not more than 4 bassinets per nursery, with an allowance of 30 square feet of floor space per bassinet with separate cubicles for each bassinet; (4) an isolation newborn unit, except when infants with communicable diseases are transferred to another department or hospital.

A separate room shall be provided for the preparation of infant formulas and stipulations are made to prevent the possibility of contamination. Further stipulation is made that no addition to, nor change in location of, the premises used for maternity and newborn care is permitted without prior approval of the plans by the Director of Public Health.

Personnel. Provision is made for organization of the obstetric medical staff of the maternity department under the directorship of an obstetrician or committee of obstetricians, and the medical staff of the newborn units under the directorship of a pediatrician or committee of pediatricians, who shall be responsible for the policies, procedures and supervision of the respective units.

The nursing service of the maternity department shall be under the supervision of a professional nurse with special preparation in maternity nursing or with experience in this field. There shall be at least one professional nurse on duty at all times to supervise maternity and newborn nursing care. At least one nurse shall be provided at all times for each 12 newborn infants. Nursing personnel regularly assigned to the maternity department shall be used exclusively in that department and other nursing personnel shall be used exclusively during any one tour of duty.

Provision is made for health supervision of persons assigned to the maternity department, certification of which shall be kept on file and open to in-

SIR ALEXANDER AND LADY FLEMING VISIT THE INSTITUTES OF HEALTH

Sir Alexander and Lady Fleming (front row center) toured the National Institutes of Health, April 8, at the special invitation of Dr. Leonard A. Scheele, Surgeon General of the Public Health Service.

Accompanying the Flemings on the tour were a number of the Directors of the Institutes and some especially invited guests. Some of the group were photographed and appear above. Front row, left to right, they are: **Dr. R. H. Felix**, Director, National Institute of Mental Health; **Mrs. U. R. Bryner**; **Sir Alexander and Lady Fleming**, herself a doctor of medicine, a research microbiologist and bacteriologist in her own right; **Dr. U. R. Bryner**, of Salt Lake City, Utah, immediate Past President of the American Academy of General Practice; **Dr. James Watt**, Director, National Heart Institute.

Second row, left to right: **Dr. I. Phillips Frohman**, Chairman, Section on General Practice, District Medical Society; **Dr. Francis Arnold**, Director, National Institute of Dental Research; **Dr. Harry Eagle**, Chief of Section on Experimental Therapeutics, Laboratory of Infectious Diseases, National Microbiological Institute; **Dr. Pearce Bailey**, Director, National Institute of Neurological Diseases and Blindness; **Dr. Victor Haas**, Director, National Microbiological Institute; **Dr. Floyd Daft**, Director, National Institute of Arthritis and Metabolic Diseases; **Dr. Norman B. McCullough**, Chief of Laboratory of Clinical Investigation, National Microbiological Institute.

A luncheon honoring the Flemings was served in the Officers' Club of the National Naval Medical Center. Following a tour of the various departments and laboratories of the Institutes, Dr. W. H. Sebrell, Chief of the National Institutes of Health, and Mrs. Sebrell gave a tea for the visitors at their home on the grounds.

On April 7, the day preceding the tour, Sir Alexander gave an address, which was open to the public, at Georgetown University on "The Story of Penicillin." His appearance before the Scientific Assembly of the American Academy of General Practitioners in Cleveland late in March was one of the highlights of that meeting.

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spection by a representative of the Department of Public Health.

Medical and nursing care and procedures. Policies and procedures shall be developed by the medical and nursing staffs of the maternity department for the use of all personnel caring for maternity and newborn patients.

Provision for the examination and care of maternity patients and of the newborn infant are set forth with additional precautions for the care of the newborn. Procedures for the preparation of infant formulas are stated with considerable specificity as are general sanitary measures to be followed by maternity department personnel.

Measures for the control of infection are delineated with special reference to infectious diarrhea of the newborn. The roles of the Department of Public Health and the hospital in carrying out investigations of any outbreak of an infectious disease are specifically stated.

Records. A register shall be kept of all maternity department admissions, deliveries, live births, still births, maternal deaths, and infant deaths.

George Maksim, M.D.
Chairman, Committee on Public Health,
The Medical Society of the District of Columbia

ANNUAL REPORT OF THE WOMAN'S AUXILIARY

Early in August last year, had you been in Washington, you would have found the President of the Medical Society of the District of Columbia, the Secretary and his staff, and myself busy with many conferences and plans. While the rest of the city's tempo was slowed down by the heat, we buzzed around impervious to such trivialities as Washington weather.

We were all interested in the same objectives, "another successful year for the Medical Society and its Woman's Auxiliary" and a real contribution to the civic welfare of our city.

The Auxiliary meeting in New York in June had been inspiring to me. All of the reports helped in some way or another with my plans for the District of Columbia the following year. The State of Pennsylvania's report on its Health Poster Contest was most stimulating. So I presented my notes on their project to the Medical Society's President, Dr. Herbert P. Ramsey, and Secretary, Mr. Theodore Wiprud, for their approval. They coöperated wholeheartedly all through the months of carrying it out. The formative stage of the Health Poster Contest flourished during those hot August days.

The Medical Society's Annual Scientific Assembly was held, October 5, 6 and 7, at the Hotel Statler. Although the doctors' task was gigantic in this annual undertaking, we assisted in getting out invitations, registering, and in other minor capacities. On Tuesday, October 6, we held a tea for the wives of doctors attending the Assembly.

Our October meeting was aflame with the enthusiasm of the new Committee Chairmen, who gave their plans for the year. During one of our August conferences, Mr. Wiprud had spoken of the great need for a complete medical news survey over a six months' period. Plans for such a project were presented at the October meeting and the Auxiliary agreed to do this job for the Medical Society. A special committee was appointed to clip and file all medical news from our four daily papers and three news magazines. At the end of six months the clippings were turned over to the doctors for a news analysis. Following the business meeting we were treated to a delightful talk on "The Role of the Doctor's Wife" by Reverend Gilbert Harthe. Father Harthe is the famous Head of the Speech Department at Catholic University.

The November meeting was devoted to routine progress reports of the various committees, but highlighted by the unanimous decision of members to send $500 to the American Medical Education Fund and $200 to Garfield Hospital's Nursing School, which was threatened with closing because of financial difficulties. We are glad to report that our check, added to many more local contributions, saved that worthy Nursing School. Our November speaker was Mr. Roland Carr, Vice President of Riggs National Bank, who gave us some valuable information on financial management.

Our December business meeting was followed by a demonstration and lecture on Christmas decorations by Mrs. Frederick Lang. During this month we manned a T.B. Christmas Seal Booth at a local bank.

In January, following our business meeting, we entertained a group of women on Capitol Hill at a luncheon in the Senate Office Building. Our guests were Mrs. Homer Ferguson, wife of Senator Ferguson of Michigan; Mrs. Walter Judd, wife of Congressman Judd of Minnesota, himself a physician; Mrs. Lamont Pugh, wife of the Surgeon General of the Navy; Mrs. Harry G. Armstrong, wife of the Surgeon General of the Air Force; Mrs. Leonard A. Scheele, wife of the Surgeon General of the Public Health Service; Mrs. Howard McC. Snyder, whose husband is Physician to the President of the United States; Madam You Chan Yang, wife of the Ambassador from Korea, who was a physician in Korea; and Mrs. William H. Sebrell, wife of the Director of the National Institutes of Health, Public Health Service. Senator Barry Goldwater, of Arizona, spoke to us.

Our February business meeting was exciting as some of our early plans were materializing. The Public Relations Committee reported the Health Poster Contest was in full swing and we were getting complete coverage by press, radio and television. The speaker for the day was Dr. Cyrus H. Maxwell, of the Washington Office of the American Medical Association, who brought us up to date on pertinent medical legislation that is being considered by the 83rd Congress.

Officers for 1954–55 were elected at our business meeting in March. They are:

Mrs. Duane C. Richtmeyer, President
Mrs. Lawrence A. Rapee, President-elect
Mrs. John E. Morris, First Vice President
Mrs. Leo C. Varden, Second Vice President
Mrs. E. Herbert Bauersfeld, Treasurer

Mrs. Joseph M. Daly, Assistant Treasurer
Mrs. Vasilios S. Lambros, Recording Secretary
Mrs. Alec A. Preece, Assistant Recording Secretary
Mrs. Robert C. Haile, Corresponding Secretary
Mrs. Luther W. Gray, Assistant Corresponding Secretary

March, a busy month, brought the Health Poster Contest to a close. We had a tea, March 18, which served a dual purpose: first, we presented Government bonds to the eight winners in the Poster Contest; second, we opened our Doctors' Art Exhibit. President Ramsey of the Medical Society was present at the tea and awarded the following prizes: $100 bonds to Oliver Gordon, Armstrong High School, and Jill Furman, Paul Junior High School; $50 bonds to Jack Kocher, Chamberlain High School, Barbara Turner, Browne Junior High School, Samuel Roberts, Merritt School, and Clarissa Garrett, Birney School; $25 bonds to Caroline Ann Jackson, Birney School, and Evelyn Williams, S. J. Bowen School. Mrs. Jaye Grollman was Chairman of the Health Poster Contest. Judges for the Contest were Mr. James Berryman, Jr., Miss Christine Sadler, Dr. Milton Greenberg, Dr. E. C. Mazique, and Dr. Daniel L. Seckinger.

In the Library of the Medical Society was hung one of the outstanding amateur art exhibits of our city. The doctors and their families have produced some excellent oils and water colors. The exhibit was open to the public three days following the private opening and Mrs. Charles Stanley White, Jr., who was in charge of the exhibit, and other Auxiliary members received some nice comments.

More than $300 was realized from the benefit bridge luncheon which followed the March business meeting.

The April business meeting featured a stimulating talk by Lady Spender, wife of the Ambassador from Australia. Her topic was "The Progress of Australian Women."

In closing I'll say a little about our own progress during this exciting year. Five nurses have been added to our scholarship aid group, bringing the total recipients to eight, since three have graduated. We have increased our subscriptions to *Today's Health* and the *Bulletin*. We have contributed substantially to the American Cancer Society, Washington Heart Association, District of Columbia Tuberculosis Association, American Red Cross, and the Community Chest during their annual fund-raising campaigns.

Our closing meeting in May, at which time the annual reports will be given, can't help but be a pleasant finale. On May 8 we are sponsoring a gala dinner-dance for the benefit of the Nurses' Aid Fund, at which time a mink stole will be raffled off. All indications point toward clearing another thousand dollars for this fund.

It has been a satisfying year, and to each member who has aided in its accomplishment, I am grateful. It was well worth making the initial effort in the heat of August, for then as now we had the full coöperation of the Medical Society's President, Dr. Ramsey, and its Secretary, Mr. Wiprud.

Mrs. Richard H. Todd
President, Woman's Auxiliary to the
Medical Society of the District of Columbia

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, March 22, 1954, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society.

Active Members

Samuel P. Bessman, 1607 North Springwood Drive, Silver Spring, Md.
Margaret Ann Clark, 4501 Maple Avenue, Bethesda, Md.
Abraham I. Gimble, 5 Fifth Street, S.E.
Margaret Elizabeth Grigsby, 2106 Savannah Street, S.E.
Harry A. Horstman, Jr., 6704 44th Street, Chevy Chase, Md.
Donald Keller, 1112 W Street, N.W.
William H. Kessenich, 2847 Gainesville Street, S.E.
James P. Mann, 1711 Rhode Island Avenue, N.W.
Richard J. Meyer, 1509 44th Street, N W.
Seamus P. Nunan, 2343 Skyland Place, S.E.
William G. Pogue, 1625 O Street, N.W.

Associate Members

Salomon N. Albert, George Washington University Hospital
Luis P. Carbonell, 2400 16th Street, N.W.
Wilton M. Fisher, 5220 Sangamore Road, Bethesda, Md.
Adrian Hogben, 3500 Woodridge Avenue, Wheaton, Md.
Robert P. Nenno, 4424 Alton Place, N.W.
Ralph F. Patten, 8641 Colesville Road, Silver Spring, Md.
Homer L. Reighard, 6114 Walhonding Road
David A. St. Martin, 9820 Dameron Drive, Silver Spring, Md.
William F. Schnitzker, 7306 Forest Road, Landover, Md.
J. Etienne Szollosi, 2 Parkway Drive, Forest Heights, D. C.

Resident-Intern Members

James M. Clements, 423 17th Street, S.E.
Nizar N. Oweida, 2337 North 11th Street, Arlington, Va.

On the Lighter Side

A hobby can be a pleasure or a chore, depending on the type and the time necessary to achieve the end result. We know of some that require a great deal of preparation in order to get down to their actual enjoyment and we know of hobbies in which the preparation for enjoyment is almost as much fun as the hobby. Art and its pursuance seems to fit comfortably in the latter category.

March 18 through 20 were the days in which doctor artists and friends of the Medical Society of the District of Columbia hung their oils and water colors in the medical library at 1718 M Street, N.W.

This reporter had the opportunity of visiting the art exhibit and was very much surprised and delighted at what he saw. He was particularly pleased with the canvas submitted by Dr. F. A. Martinez, titled "My daughter Margo," which was a striking portrait of a very beautiful girl done in vibrant colors with a fine attention to detail that appealed to these tired eyes. The Doctor's second canvas, "Cuban Behio," was also carefully done.

Dr. George Ruhland had submitted four excellent paintings, titled "Frosty Morning," "Grand Tetons," "Tired," and "Indian Trail." The first canvas was exceptionally well done both in choice of subject matter and in technic.

Dr. Lester Burtnick (Md. '37) had a very presentable canvas, "Washington Spring," and Dr. Allen Widome's offerings, "Arrangement with Sombrero" and "Country Landscape," were done with an eye for detail and color that gave a pleasing effect.

Dr. Henry C. Macatee had four paintings and Dr. Robert B. Nelson one, all excellent. Dr. J. Thomas Schnebly's "Snow" was good, and Dr. Charles Geschickter had four very good landscapes scattered throughout the exhibit. Dr. W. Montague Cobb and Dr. Maurice H. Herzmark, with two pictures each, were also among the talented exhibitors.

The real surprise of the art show was the paintings done by the junior artists, Richard Todd, Margo Nolan, Mimi Paul, and Robert Bosworth, Jr. These kids revealed great talent, and if they progress as they normally should, they will be able to exhibit with the very best in the future.

There were a number of excellent paintings done by members of the Woman's Auxiliary, but space does not permit our mentioning the names of the exhibitors nor the titles of the exhibits; suffice it to say that our assistant editor, Miss A. Louise Eckburg, had two exceptionally good offerings on the walls.

The judges chose "Chrysanthemums" done by Mrs. Fay Widome as first blue ribbon prize winner; "Madonna and Child" second prize, done by Miss Margo Nolan (age 12); and "Seascape," third prize, submitted by Dr. Paul Zehfuss. The honorable mention class found Robert Bosworth, Jr. (age 17) first with his "Snowstorm," Florence T. Bosworth second with "Twilight—Gaspé Fishing Village," and Mrs. Jed Pearson third with "Leaves and Flowers."

BOWLING NEWS: The D. C. Medical Bowling League has completed another six weeks' award session. The prize winners were as follows: Dr. Richard J. McNulty of Sibley #1 team, the Meredyth Pharmaceutical Company award for individual high game of 166; Dr. Robert R. Montgomery, Captain of the Emergency #1 team, the District Wholesale Drug Corporation award for second high individual game of 135; and Dr. Blaine H. Eig, of George Washington team, the Peoples Drug Stores, Inc. award for individual high set of 383. The high team game for the six weeks' session, rolled by the Doctors team, captained by Dr. W. Robert Perkins, was 579. The high team set of 1,712 was compiled by the George Washington team captained by Dr. John W. Price, who is also Vice President of the League.

The teams with their wins and losses follow: first, Casualty (51–24); George Washington, second (50–25); third, Sibley #1 (45–30); fourth place, Columbia, Suburban and Sibley #2, all tied at 43 wins and 32 losses. The fifth place is also tied, with Children's, Prince Georges, and Washington Hospital Center, 40 wins and 35 losses. These teams follow in order: Georgetown (34–41), Doctors (33–42), Emergency #2 (31–44), Garfield (30–45), Good Hopers (27–48), Emergency #1 (26–49), and last in the League Providence with 25 wins and 50 losses.

The bowling season is rapidly coming to a close, and in the next issue of the ANNALS the final standings of the teams and all the prize winners will be found in this column.

J. EARL KADAN, M.D.

News and Personals

MEETINGS—Past and Future

The American Medical Association will convene for its 103rd Annual Session in San Francisco, Calif., June 21–25. Officers of the Society planning to attend the meetings of the House of Delegates are Dr. Herbert P. Ramsey, President; Drs. Hugh H. Hussey and Raymond T. Holden, delegates to the AMA; and Theodore Wiprud, Secretary.

The National Tuberculosis Association-American Trudeau Society will hold their annual meetings jointly in Atlantic City, N. J., May 17–21. Headquarters will be in the Ambassador Hotel.

This will be the 50th anniversary meeting of the National Tuberculosis Association and an outstanding program has been arranged. There will be prominent speakers from the United States and abroad. The Armed Forces Institute of Pathology is preparing an exhibit on "The History of Tuberculosis" to commemorate the anniversary meeting.

The Sixth Scientific Assembly of the American Academy of General Practice, which convened in Cleveland, March 22–25, reported a total registration of 5,817, with a total physician attendance of 2,872. Two Washington physicians participated in a Symposium on Tuberculosis. They were **Dr. Sol Katz,** Associate Editor of GP and Clinical Adjunct Professor of Medicine, Georgetown University School of Medicine, **and Dr. Edgar W. Davis,** Professor of Thoracic Surgery at Georgetown. The third member of the panel was Dr. William W. Stead, Assistant Chief of Tuberculosis Service, Fitzsimmons Army Hospital, Denver.

At the meeting of the **Section on Neurology and Psychiatry,** March 4, the following officers were elected for the coming year:

Dr. Harvey H. Ammerman, *Chairman*; Dr. Leon Salzman, *Vice Chairman*; Dr. Stacy Rollins, *Secretary-Treasurer*; Drs. Harold Stevens and William T. Spence, *members of the Executive Committee.*

Drs. Zigmond Lebensohn, Desmond S. O'Doherty and Clarence Greene were appointed to the Program Committee.

The luncheon meeting of the **Metropolitan Health Officers' Association,** April 14, at the Washington Golf and Country Club, was devoted entirely to the medical program of civil defense. Dr. H. C. Huntley, Medical Director of Region II of the Federal Civil Defense Administration, discussed recent developments in the medical services. Dr. John M. Whitney, Training Officer, FCDA, outlined briefly the training programs in the medical field of civil defense. Recent developments in radiological warfare were reviewed briefly by Mr. Jack Greene, Chief of the Radiological Division of FCDA. Mr. Greene described several types of appliances, such as radiological meters, which are now being distributed to the states and cities. Dr. Daniel L. Seckinger, President of the Association, presided at the meeting.

Dr. Charles P. Ryland, President of the **District Rheumatism Society,** presided at a meeting of the Society in the Medical Society's building, March 24. Guest speaker was Dr. Joseph Lee Hollander, of Philadelphia, Director of the Arthritis Clinic at the University of Pennsylvania Hospital. He spoke on "The Rise and Fall of Antiarthritic Drugs."

The George Washington University Medical Society met on April 21 in the Medical Society's auditorium. Dr. David M. Davis, Professor of Urology, Emeritus, Jefferson Medical College, Philadelphia, was the guest speaker. He discussed "Urinary Suppression."

GENERAL NEWS

The Executive Board of the Medical Society of the District of Columbia met in regular session, March 22. Upon the recommendation of Dr. Frederick O. Coe, Vice President of the Washington Academy of Sciences representing the Medical Society, the Board voted to contribute $50 to the Annual Science Fair sponsored by the Academy and held at the American University, April 9-13.

Vice Admiral Joel T. Boone, M.C., U.S.A. (Ret.), Chief Medical Director, Veterans Administration, was proposed for Honorary membership in the Society.

Dr. Thomas C. Thompson was appointed to the Classification Committee, succeeding Dr. Clifford E. Bagley.

Dr. Joseph H. Watson represented the District Medical Society at a meeting, March 16, of the Greater Washington Educational Television Association, Inc. for the purpose of creating an Advisory Council to the GWETA. The Medical Society has been invited to become affiliated with the Council, which is being formed to insure Washington citizens that they will have the kinds of programs they consider most beneficial. The Association is housed at 2038 Eye Street, N.W. The American Medical Association is represented on the National Citizens Committee for Educational Television by Dr. W. W. Bauer.

Originally activated in January, 1953, the 115th Mobile Surgical Hospital, District of Columbia National Guard, has been redesignated as the **115th Evacuation Hospital,** effective March 4, 1954. The original hospital, with a capacity of 60 patients, was the first of its kind assigned to the National Guard of the United States. Recently the Surgeon General of the Army has allocated 18 hospitals to the National Guard. It was in line with this policy that the redesignation of the hospital was brought about.

The new unit, of 400-bed capacity, will be commanded by Colonel S. Ross Taggart. As reorganized the hospital will include both a Medical Service and a Surgical Service, with all of the surgical specialties represented. Captain James E. Chapman has assumed duties as Chief of the Medical Service. Other members of the staff include Major DeRuyter A. Butler, Captain Edward A. Partenope, and First Lieutenant John T. Harrigan. Additional staff vacancies for medical officers exist up to the rank of Lieutenant Colonel.

The hospital staff meets weekly on Thursday evenings at the District of Columbia National Guard Armory at 8 o'clock. Physicians and medical personnel interested in the unit should contact Colonel Taggart or Dr. Chapman.

Twenty-five year Service Awards were presented to **13 faculty members of George Washington University School of Medicine** at the Annual Alumni Luncheon, held at the National Press Club, March 20. Nine recipients were members of the District Medical Society, namely:

Dr. George W. Creswell, Assistant Clinical Professor of Dermatology and Syphilology

Dr. Henry L. Darner, Clinical Professor of Obstetrics and Gynecology

Dr. Benjamin F. Dean, Jr., Assistant Clinical Professor of Surgery

Dr. Charles R. L. Halley, Clinical Professor of Medicine

Dr. Clayton H. Hixson, Associate in Obstetrics and Gynecology

Dr. H. J. Russell McNitt, Associate in Obstetrics and Gynecology

Dr. Aaron Nimetz, Assistant Clinical Professor of Pediatrics

Dr. Hyman D. Shapiro, Assistant Clinical Professor of Neurology

Dr. Thomas C. Thompson, Clinical Professor of Urology

Presentation of the awards was made by Dean Elmer Louis Kayser, Past President of the General Alumni Association. Chief Justice Earl Warren was the principal speaker at the luncheon.

Georgetown University School of Medicine announces the establishment of the $3,000 **Allen Kander Research Fund,** which has been set up for the advancement of research in cardiac surgery by Mr. Kander, 1701 K Street, N.W., Washington. Mr. Kander will give the institution $250 a month for at least a year. **Dr. Charles A. Hufnagel,** Assistant

Professor of Surgery, will conduct the research.

Georgetown University also announces the receipt of a gift of $5,000 from **Francis Cardinal Spellman,** of New York. The money will be used to defray part of the construction cost of a new research wing on the University Hospital.

George Washington University has received a grant of $10,000 from the **Lasdon Foundation** which will enable **Dr. Monroe J. Romansky,** Associate Professor of Medicine, **and Dr. Sol Katz,** Adjunct Clinical Professor of Medicine, to conduct further research in the field of tuberculosis. The laboratory and clinical studies are being carried on at the District of Columbia General Hospital. One phase of the research is to find a means of maintaining long-term treatment by preventing the tuberculosis bacteria from developing resistance to the drugs used for treatment. Support for this project was first given by the Lasdon Foundation in 1952.

At the annual banquet of the **Smith-Reed-Russell Society,** honorary scholastic society of George Washington University School of Medicine, which was held at the Hotel Statler, March 16, three members of the District Medical Society were inducted into honorary membership. They were **Dr. Charles S. Coakley,** Professor of Anesthesiology; **Dr. Calvin T. Klopp,** Assistant Clinical Professor of Surgery and Director of the University's Cancer Clinic; **and Dr. William W. Stanbro,** Professor of Radiology.

The banquet speaker was Robert C. Cook, Editor of the *Journal of Heredity* and professorial lecturer on medical genetics at the Medical School. He spoke on "The Doctor and the Genes."

The headquarters office of the **Student American Medical Association** has been moved from the AMA Building across the street to the Boyce Building. The new address is Room 724, Boyce Building, 510 North Dearborn Street, Chicago 10, Illinois. The telephone number is Delaware 7-2544.

Ceremonies held at the D. C. General Hospital, April 8, marked the opening of the **Moran Library for Doctors and Nurses** as a joint endeavor. Miss Laura E. Stewart, formerly librarian for the Hagner Memorial Library at Garfield Hospital, has been employed as its first full-time librarian. The nurses' library was originally established in 1948 as a memorial to Miss Catherine E. Moran, who was Superintendent of Nurses from 1922 to 1945.

The library is housed in the Nurses Home. Miss Stewart announces that it will be open Mondays, Tuesdays and Thursdays from 12:30 to 9 p.m., and on Wednesdays and Fridays, from 8:30 a.m. to 5 p.m.

Georgetown University School of Medicine has received $30,113 in grants from the **Public Health Service,** most of the sum for new projects. Specifically the grants are: $9,996 to **Dr. Edward D. Freis,** Professor of Medicine, for work in the chemotherapy of high blood pressure; $12,720 to **Dr. George E. Schreiner,** Instructor in Medicine, **and Dr. Laurence H. Kyle,** Assistant Professor of Medicine, for a study of certain functions of the kidney; $2,397 to Dr. Arnall Patz, ophthalmologist, for studies on eye disease; and a renewal grant of $5,000 to **Dr. Vincent J. Dardin,** Clinical Professor of Pathology, for a cancer training project.

Reports on research being conducted at the **Cancer Clinic of George Washington University School of Medicine** were presented by staff members before the meeting of the **American Association for Cancer Research,** in Atlantic City, N. J., April 10–12. Two papers presented by the Clinic staff were: "Pathways of Intra-arterially Administered HN-2," Drs. Calvin T. Klopp, Eberhard Trams, and Ivor Cornman; "Effects of Bile Duct Ligation on Some Transplantable Mouse and Rat Tumors," Drs. Alexander Symeonidis, Ivor Cornman, Eberhard Trams and Calvin T. Klopp. Dr. Symeonidis is on the staff of the National Institutes of Health but collaborated with the staff of the Cancer Clinic in this study.

New officers of the **Alexandria Medical Society,** elected April 8, are:

Dr. Christopher J. Murphy, Jr., *President*; Dr. F. Preston Titus, *Vice President*; and Dr. Thomas F. McGough, *Secretary*.

Providence Hospital has received a check of $150,000 from the **Philip Murray Memorial Foundation, Inc.** to be used for a clinic in the new building. Named after the late President of the CIO, it will be known as the Philip Murray Clinic.

PERSONALS

Dr. Leonard A. Scheele, Surgeon General of the United States Public Health Service, was named the **26th Kober Lecturer** by the Executive Council of the Association of Military Surgeons of the United States. The Kober Lecture was held at Georgetown University School of Medicine, March 30, in Gaston Hall. Dr. Sheele's address was entitled, "World Health—a Challenge of Medicine."

Dr. Scheele is President of the Association of Military Surgeons, an Associate member of the Society of Medical Consultants to the Armed Forces, and an Honorary member of the District Medical Society.

In 1934 Dr. Scheele received his medical degree from Wayne University School of Medicine. He was commissioned in the Regular Corps of the Public Health Service on July 10, 1934. After short routine assignments at foreign quarantine stations, he was assigned in 1936 to the Maryland State Health Department for field experience in public health administration as a county health officer in Queen Anne's County.

In 1937, Dr. Scheele was assigned to the National Cancer Institute for advanced training in cancer diagnosis, treatment and research. He served as a Fellow at the Memorial Hospital in New York City until 1939, when he returned to the National Cancer Institute as a member of its staff. There he set up and administered the first cancer control program of the Public Health Service. In 1945 he was made Assistant Director of the Institute and its Director in 1947.

Dr. Scheele was appointed Surgeon General of the Public Health Service on April 16, 1948 and was reappointed to this office on April 16, 1952.

Dr. William R. Stovall is the eighth recipient of the Theodore C. Lyster Award, given annually for outstanding achievement in the general field of aviation by the Aero Medical Association. At the Honors Night Dinner, March 31, he was recognized for his contribution to the field of civil aviation medicine, particularly for his leadership in obtaining recognition of aviation medicine as a specialty. The Lyster Award was established in 1947 to honor the memory of the late Brigadier General Theodore C. Lyster, who was the first Chief Surgeon, Aviation Section, U. S. Army Signal Corps. Dr. Stovall is immediate Past President of the Association and Past President of the D. C. Chapter of the American Academy of General Practice.

Dr. Howard T. Karsner, Medical Research Advisor to the Surgeon General of the Navy, was reëlected Chairman of the Advisory Medical Board of the Leonard Wood Memorial (the American Leprosy Foundation) at its annual meeting in Washington, April 8. Dr. Karsner is an Associate member of the District Medical Society. The Surgeons General of the Army, Navy and Public Health Service, Major General George E. Armstrong, Rear Admiral Lamont Pugh, and Dr. Leonard A. Scheele, respectively, were appointed to the Board.

Dr. A. Magruder MacDonald was one of eight Georgetown University alumni honored for distinguished service to the country, the city and their alma mater, by the **Georgetown University Alumni Association.** The awards were presented by **Dr. Oscar B. Hunter, Jr.,** President of the Association, March 17, at the Fourth Annual Luncheon of the Association, held at the National Press Club. Dr. MacDonald, of the Class of 1915, is District Coroner and a member and Past President of the District Medical Society. He was a lecturer for many years on medical jurisprudence at Georgetown University and the National Police Academy of the FBI. A veteran of World War I, he also served during World War II as medical advisor to the Director of Selective Service.

Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, was one of 12 outstanding employees of the Department of Health, Education and Welfare to receive honor awards from Secretary Oveta Culp Hobby, April 9, and one of 4 to receive the Distinguished Service Award. Dr. Overholser was recognized for "his outstanding contributions to humanity in the field of mental health."

Dr. Donald R. Sickler has been appointed to succeed **Dr. Vernon M. Padgett** as head of the

Division of Tuberculosis of the District Health Department. Dr. Sickler, a graduate of George Washington University School of Medicine, interned at the District General Hospital. He served as resident medical officer in tuberculosis at that Hospital from 1939 to 1942, when he entered the Army. After leaving the Army, with the rank of Major, in 1946, Dr. Sickler served five years as a medical officer in the Health Department. Since June, 1952, he has been associated with the Veterans Administration Loch Raven Hospital, Baltimore, where he was engaged in a tuberculosis research program.

GEORGETOWN CLINICAL SOCIETY HONORS DR. GANNON

Dr. James A. Gannon (center left) receives Georgetown Clinical Society's Award of Merit from Dr. Gerald H. McAteer, President of the Society. Flanking the principals are Dr. Edward A. Kelly (left), Vice President, and Dr. Francis L. Zinzi, Secretary-Treasurer of the Society.

Dr. Padgett, who has been head of the Division since 1950, is now on leave of absence and is working with the Public Health Service.

Both Drs. Sickler and Padgett are Active members of the District Medical Society.

Dr. John D. Schultz, Jr. has been named head of the Psychiatric Division at District General Hospital by the District Commissioners. Dr. Schultz, an Active member of the District Medical Society, has served as Director of Georgetown University's Outpatient Psychiatric Clinic and as Assistant Professor of Psychiatry.

Dr. Everett J. Gordon, who is Chief and Director of the Orthopedic and Prosthetic Appliance Clinic of the Veterans Administration in the Middle Atlantic Region, participated in a demonstration of the latest developments in prosthetic research before the Veterans Affairs Committee of the House of Representatives, April 7. In the exhibition, which was sponsored by the National Research Council, Dr. Gordon demonstrated the value of the clinic team approach in the solution of the problems of severely disabled amputees.

At the meeting of the **Georgetown Clinical Society** at Hotel 2400, March 16, **Dr. James A. Gannon** was presented the Award of Merit for his long and distinguished service to medicine.

Dr. Gannon, an alumnus of Georgetown University School of Medicine, served in the Department of Medicine at Georgetown as an instructor from 1908 to 1914, and as Associate Professor of Surgery from 1919 to 1932. He was physician to the poor from 1910 to 1914 and Chief of Staff and surgeon of the D. C. General Hospital from 1924 to 1928.

He was Vice President of the D. C. Board of Education from 1940 to 1952. Since 1940 he has been Chairman of the Board of Draft Appeals. Last year he was made a member of the Council of Thirteen, which advises the Commissioners on Civil Defense.

Dr. Gannon is a Life member of the Medical Society of the District of Columbia, a Fellow of the American College of Surgeons, and Past President of the Washington Academy of Surgeons. He has contributed numerous articles to medical and other scientific journals.

Dr. Gerald H. McAteer, President of the Georgetown Clinical Society, presented the award to Dr.

Gannon and commented on his long and faithful service to Georgetown and to the people of Washington.

Dr. Albert H. Holland, Jr. has been appointed **Medical Director of the Food and Drug Administration.** Dr. Holland, Medical Director of the Armour Laboratories in Chicago since January, 1951, succeeds Dr. Irvin Kerlan, who has been Acting Medical Director since July, 1952.

Dr. Howard T. Karsner, Medical Research Advisor to the Surgeon General of the Navy, was invited to participate in a Symposium on the Origins of Drug Resistance and Related Problems, which was held at the Hotel Statler, March 25–27. The Symposium was presented by the University of Pennsylvania and the Navy's Office of Naval Research. Dr. Karsner was moderator of the session on Resistance Factors, Infectious Agents and Cancer Cells, March 26.

Dr. Wallace M. Yater was the discussant of a paper on "Coronary Artery Disease in American Soldiers Killed in Action in Korea," authored by Dr. William T. Enos and presented at a general session of the 35th Annual Meeting of the American College of Physicians in Chicago, April 5–9. Dr. Yater was also moderator of a clinicopathologic conference.

At this meeting Dr. Yater was reëlected a Regent of the College.

Dr. Edward J. Stieglitz and Dr. James M. Moss attended and participated in the Fourth Annual Scientific Assembly of the Virginia Academy of General Practice, which was held at the Jefferson Hotel in Richmond, May 5, 6 and 7. Dr. Stieglitz read a paper on "Anticipatory Medicine in Later Maturity" and Dr. Moss discussed "The A.D.A. Food Exchange Tables" at an afternoon meeting, May 5, sponsored by the Virginia Diabetes Association.

Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, gave a brief address before the National Conference on Care of the Long-term Patient, which met in Chicago, March 18–20. The Conference was held under the auspices of the Commission on Chronic Illness, with the sponsorship of the American Hospital Association, the American Medical Association, the American Public Health Association, the American Public Welfare Association, and the Public Health Service. Forty national organizations and agencies concerned with chronic illness sent official representatives.

Dr. Robert Stolar presented a paper on "Dermatologic Lesions about the Oral Cavity—Diagnostic Aspects" at a table clinic, March 17, during the 1954 Postgraduate Clinic of the D. C. Dental Society, which was held at the Shoreham Hotel for four days beginning March 14.

Vice Admiral Ross T. McIntire, MC, USN (Ret.), personal Physician to the late President Franklin D. Roosevelt, and an Honorary member of the District Medical Society, was cited for his work as Chairman of the President's Commission for the Employment of the Physically Handicapped. He was awarded a plaque and citation at the Junior Chamber of Commerce luncheon in the Burlington Hotel, March 25, by District Commissioner Renah Camalier, in behalf of the Jaycees and the Commissioners' Committee for Employment of the Physically Handicapped. Dr. McIntire resigned his position as Chairman of the Commission, April 1, to seek the Democratic nomination for Congress from California's 30th District.

Dr. Kenneth R. Nelson has resigned as Director of the Red Cross Regional Blood Program to enter private practice. He has been succeeded by **Dr. Raymond Osborne Dart,** formerly Director of the Southeast Texas Defense Blood Center.

A retired Major in the Army Medical Corps, Dr. Nelson has practiced privately in Washington and on the West Coast. He was a staff physician at the Northern Permanente Foundation in Vancouver, Washington.

Dr. Dart, a retired Brigadier General, has served as pathologist at the Soldiers' Home, Columbia Hospital, and Washington Sanitarium. He has been Director of the Army Institute of Pathology and consultant to the Surgeon General and the Armed Forces Institute of Pathology.

At the 25th Annual Meeting of the Aero Medical Association at the Hotel Statler, March 29–31,

Dr. Aris Carpousis and Dr. Ludwig G. Lederer were among the participants. Dr. Carpousis spoke on "Aviation and Teeth with Special Reference to Aerodontalgia," March 29. On the same day, Dr. Lederer participated in a Panel Discussion on The Aging Pilot.

Dr. Seymour Alpert, Associate Professor of Anesthesiology, George Washington University School of Medicine, addressed the Annual Meeting of the International Academy of Anesthesiologists in Chester, Pa., March 17. The subject of his discussion was "Endotracheal Anesthesia."

Drs. Sol Katz, George F. McCormick, Patrick Storey, and Monroe J. Romansky were authors of two papers presented at the 13th Conference on the Chemotherapy of Tuberculosis, sponsored by the Veterans Administration, the U. S. Army and Navy, in St. Louis, February 10. The papers presented were "The Use of Combined Intermittent Streptomycin and Isoniazid in Pulmonary Tuberculosis," Drs. Katz, McCormick, Storey, and Romansky; "A Pilot Study of 1595 (Salizid), an Isonicotinic Acid Hydrazide Analogue" by Drs. Katz and McCormick.

Dr. Murray M. Copeland, Professor of Oncology, Georgetown University School of Medicine, gave an address in Baltimore, March 31, before members and friends of the Maryland Division of the American Cancer Society at the launching of the annual campaign for funds in the State of Maryland.

Dr. Stanhope Bayne-Jones, Technical Director of Research, Research and Development Division, Office of the Surgeon General of the Army, was in New Orleans, March 25, 26 and 27 to attend the first meeting of the newly created Board of Visitors of Tulane University, to which he was recently elected. He will serve a three-year term on the Board.

CALENDAR OF SPEAKERS

The following members of the Medical Society of the District of Columbia have addressed lay groups during the past several weeks. The Society maintains a Speakers Bureau, sponsored by the Committee on Public Information, through which requests for speakers for lay groups, including radio programs, can be filled.

Date	*Speaker*	*Subject or Title*	*Organization*
March 8	Dr. George Maksim	Health in Grade School Children	Beers Parent-Teachers Association
March 11	Dr. Julius Schreiber	Your Stake in Mental Health	Men's Club, Hebrew Home for the Aged
March 21	Dr. Tiffany Lawyer	Muscular Dystrophy	Washington Chapter, Muscular Dystrophy Association
March 23	Dr. Margaret M. Nicholson	Morals Among Our Teen-agers	St. Cecilia's Parents Association
March 27	Dr. George Schreiner	Specialized Tests of Kidney Function	Seminar of D. C. Society of Medical Technologists
March 29	Dr. Henry P. Laughlin	A New Look in Your Outlook	Bethesda-Chevy Chase Branch, American Association of University Women
March 30	Dr. Douglas Noble	Problems of the Middle Years	Good Neighbor Club, All Souls Unitarian Church
April 9	Dr. Anthony Zappala	Rehabilitation of Alcoholics	Executive Board, Flynn's Half-Way House
April 14	Dr. Julius Schreiber	Emotionally Healthy Women	Mills College Alumnae
April 20	Dr. Julius Schreiber	Emotional Problems of Young Adults	George Mason School Parent-Teachers Association, Alexandria
April 25	Dr. Julius Schreiber	Getting Along with Each Other	Young Adult Group, All Souls Unitarian Church

On March 24, while in New Orleans, Dr. Bayne-Jones delivered a lecture to the members of the Alpha Omega Alpha Society, national honorary fraternity for medical students, at the Louisiana State University School of Medicine. His subject was "Military and Civilian Preventive Medicine." Dr. Bayne-Jones retired from the Army Medical Corps as Brigadier General; during World War II he was Chief of the Preventive Medicine Division, Office of the Surgeon General. He is a native of New Orleans.

Dr. Robert P. Odenwald addressed the Family Division of the National Catholic Welfare Conference in New Orleans, March 24, on the subject, "Some Important Factors in the Development of Children."

Dr. W. Montague Cobb was recently elected Vice President of the American Association of Physical Anthropologists at a meeting of the Association at Antioch College in Ohio.

Dr. Peter D. Comanduras was one of the contest judges for a school essay project for 11th and 12th grade students in the District of Columbia, sponsored by the District of Columbia Division of the American Cancer Society. Dr. Comanduras is a member of its Board of Trustees. "Youth Can Strike Back at Cancer" was the subject of the essay contest, which closed March 15.

Dr. Roland Bieren, obstetrician on the staff of Group Health Association, is attending a series of surgical meetings in the British Isles this month. Dr. and Mrs. Bieren sailed in April on the Queen Elizabeth. After a tour of England they visited Glasgow, Scotland, where they were the guests of a member of the University faculty on May 8. Dr. Bieren also participated in conferences at the Universities of Glasgow and Edinburgh.

On May 13, in Harrogate, they were entertained by members of the Association of Surgeons of Great Britain and Ireland, and Dr. Bieren attended meetings at the University of Leeds. Returning to London, he was present at the sectional meetings of the American College of Surgeons.

Dr. Isidore Lattman announces his retirement from the private practice of radiology; he will devote his time exclusively to the X-ray Department of Children's Hospital. The X-ray firm of Drs. Groover, Christie and Merritt has taken over Dr. Lattman's practice.

Dr. John F. Stapleton is moving to Worcester, Mass. this month to become Director of Medical Education at St. Vincent's Hospital, soon to become a teaching affiliate of Georgetown University School of Medicine. In his new assignment Dr. Stapleton will continue on the faculty of Georgetown as Clinical Instructor in Medicine.

CORRESPONDENCE

WASHINGTON, D. C., April 6, 1954

TO THE EDITOR:

I appreciated your printing my comments on "Nonservice-connected Disabilities and the VA" in the December issue of the MEDICAL ANNALS. Publication of Admiral Boone's answer is even more gratifying because it clearly shows that the conscience of the Veterans Administration is beginning to be remorseful.

The Medical Director has again demonstrated so well his uncanny ability to evade the facts by glib rhetoric and emotional appeal. His mastery of this technic is all too well known to the members of Congressional committees who have struggled to obtain accurate information on the method of function of the VA medical program. The recent hearings before the Appropriations Committee were filled with attempts to avoid direct factual answers. But these days are far too serious to allow glibness to dissuade us from our purpose. To accept the circumlocution is to accept defeat to a disease far more destructive than cancer, for the disease of socialism destroys incentive and leaves the soul a helpless mockery, drifting with life and exerting no influence toward good for the individual, the family, the country, or the world.

The Admiral, having accepted his post after leaving the Navy, it is hoped has no dreams of "empire," but such cannot be said for those associated with him. Their ambition for power may well be the stroke that destroys us as a progressive nation. Therefore, I feel obliged to point out the elisions and half-truths in the Admiral's letter.

Point 1. The Admiral claims there is nothing new about medical benefits for veterans.

Comment: It is true that since Public Law No. 2—73rd Congress 1933, Congress approved medical care for veterans, but before World War II the use of VA hospital care for nonservice-connected disabilities was never so flagrantly abused. With 82 per cent of VA admissions nonservice-connected, including operations for appendicitis, hemorrhoids, fractured arms, etc., the claim that these men could not afford private care just does not make sense. To emphasize the point, up until June, 1953, some $7,200,000 was collected by the VA from private medical and hospital insurance companies for care for veterans holding their policies, and this from men who couldn't afford medical care. Recently the VA revised its 10-P-10 forms so that the veteran must state his average means. This was done after Congressional hearings in which the Medical Veterans Society brought out how poorly the VA was complying with the original intent of Congress in 1933. The question is reduced to absurdity if one accepts the Admiral's figures on the numbers of veterans and the number of VA hospital beds. As the Medical Director says, 81,000 beds served 4 million veterans of World War I and now we have 20 million, with 1 million new veterans each year. By 1965 the number of beds required by these "indigents" will be 800,000. If that should come to pass the indigent will be the taxpayer.

Point 2. The Admiral completely slips past the point that the VA has on its payroll many of the service officers of veterans' service organizations.

Comment: The fact of the matter is that such is the case and that these men are well known to the Admiral as well as to members of Congress. So far, however, the loud and vociferous voice of these service organizations has been sufficient deterrent to any action against them.

Point 3. The Admiral states that the veteran must sign a form warning against making any false statement, violation of which would subject the veteran to possible prosecution.

Comment: Anyone who has witnessed a patient's admission to a VA hospital knows that the applicant must sign 5 or 6 forms which are usually spread out in a fashion not conducive to thoughtful decision. Furthermore, these men are told that if in their opinion they are unable to pay that is sufficient. The point is that the Administrator of the VA medical program is not emphasizing this as he should.

Point 4. "Twenty-five per cent of GM and S patients treated in VA hospitals are referred to the VA by private physicians and hospitals after their funds are exhausted."

Comment: This is a leading statement which any doctor can answer very readily because we take care of these people every day without charge. They are our patients, and we would never desert them. The interesting question is, what about the other 75 per cent? If Admiral Boone would only admit the 25 per cent whom he claims are indigent, the 75 per cent would be taken care of properly in their own community at their own expense. I did not expect the Admiral to admit this so readily, but the problem would be corrected if this alone were made right.

Point 5. Loss of doctors, nurses and technicians to VA.

Comment: Admiral Boone makes a great deal over the salaries of doctors in VA compared to the man in active practice. He fails to acknowledge the 5-day, 9–5 work-week, no night calls, and the retirement pension.

My emphasis was not on trained doctors who go to the VA, but rather on the fact that the VA pays residents $300 per month, which is considerably higher than community hospitals pay. Nurses also are attracted by the short hours and better pay, and it is absolutely ludicrous for anyone to claim civilian hospitals struggling to make ends meet could ever pay competitive salaries. This hardship imposed on patients in community hospitals is the most deplorable situation of the entire problem. Only a complete disregard for community welfare could ever allow the VA to impose their plans of expansion on the towns in which they exist. But empire builders do not concern themselves with the people who concern the doctor, his patients. The medical profession has received an immensity of abuse for all of its troubles on behalf of those it serves.

As far as technicians are concerned, the Admiral claims the biggest training program in the country, yet in 1953 only 6 VA hospitals were training technicians. They averaged 8 apiece. Hardly a large training program.

The impact of the VA hospitalization program is a horribly vicious circle. All community hospitals have suffered because of the VA expansion program. They have lost their patients, and they have lost their house doctors, nurses and technicians.

In 1952 the VA medical program had 2,021 residents, while private hospitals had 8,151. Fully 25 per cent of the doctors of the country were in the VA program. The vacancies in house staffs of community hospitals were 26 per cent. This destructive influence on the community teaching hospitals must stop. The people of the country must be educated to the point that the VA is destroying their most vital community institutions, and if allowed to continue the community hospitals will deteriorate to the status of nursing homes without nurses.

This problem inflicted on community hospitals is not unpremeditated. The following TWX from VA headquarters to all VA hospitals clearly defines what the VA is after. This is an example of empire building of the most miserable sort because it involves human lives, and if there were doubts before seeing this, afterwards they are certainly dispelled.

"VETERANS ADMINISTRATION CENTER

Wichita 8, Kansas, July 17, 1953

(THE FOLLOWING TWX WAS RECEIVED FROM ADMIRAL BOONE, CHIEF MEDICAL DIRECTOR, VETERANS ADMINISTRATION, CENTRAL OFFICE, WASHINGTON, D. C., DATED JULY 16, 1953.)

"At recent hearings before Congressional Appropriations Committees, the status of the VA hospital program was fully examined and its needs were fairly appraised. As a result, the Congress has indicated its intent to provide sufficient funds for more complete utilization of VA hospital facilities, thereby permitting hospital care sufficient to provide more adequately for the needs of sick and disabled veterans. This fact has direct implications for all of us in the VA hospital program. We must recognize these implications at once and begin to act on them immediately. The size of the intended appropriation for the VA hospital program implies Congressional intent that a greater number of sick and disabled veterans be hospitalized by VA, whether they be young or old, acutely or chronically ill. Within the limits of available funds, hospitals will be provided the financial means to enable them to operate the number of beds needed to accomplish this. The means having been provided, the burden is now on us—to hospitalize eligible veterans and to give them the best medical care possible. The utmost coöperation and interaction of VA hospitals, Regional Offices, Area Medical Directors, and Central Office are required. The full utilization of our beds necessarily requires close liaison and coöperation between hospitals and Regional Offices. A mutual understanding of the medical and administrative problems common to both is a requisite to the coöperative efforts which must be made by each to insure continual maximum utilization of VA beds. In the expansion of our patient load which increased funds will now make possible, you should not overlook the group of veterans with medical, surgical or neurological disabilities of a geriatric nature. Geriatric illness is rapidly becoming one of the major medical problems in the United States. It is now, and will become in greater measure, a particularly pressing problem for VA, in what is actually a very near future.

"The veterans population is a relatively fixed and aging one with an increasing incidence of the geriatric diseases. In order to become more familiar with these diseases it is essential at the present time to begin to develop policies governing admission of patients with such conditions if we are to be prepared to cope with them in increasing volume and to set up bed services to provide for them. I propose to suggest at a later date other areas of patient needs to which special attention must be devoted. It was explained to Congress how limitation of funds resulted in idle beds which we could not operate and how this made it impossible for us to meet adequately the needs of veterans. Congress has now indicated its intent to provide a remedy. We shall meet the challenge now facing us—to care for all sick and disabled veterans eligible for and in need of hospital treatment—to merit the confidence publicly expressed.

"I ask you and your staff to proceed at once to develop means for increasing your occupancy and for reactivating any closed beds, by adjusting your local hospital policies and methods, to admit and care for as many as possible of the sick and disabled veterans who have called upon us for needed hospital care. (10E) (Following paragraph is from the Veterans Administration Information Service Bulletin, June 10 through June 18, 1953)

'(2) In connection with Maintenance and operation of hospitals, the appropriation is predicated on the staffing and operation of 114,315 beds during f.y. 1954, and if a lesser number is provided such appropriation shall be expended only in proportion to the number of beds staffed and operated.'

/s/ R. W. Hille, M.D.
Chief Medical Officer"

Oscar B. Hunter, Jr., M.D.
Chairman, Veterans Affairs Committee, National Medical Veterans Society

BOOK REVIEWS

Cure Your Nerves Yourself. Louis E. Bisch, M.D., Ph.D. Price, $3.50. Pp. 247. New York: Wilfred Funk, 1953.

It is doubtful if any true neurotic has ever been *cured* by reading a book. If so, this happy fact has escaped me. Dr. Bisch, who has already written at least six books on psychiatry for the lay public, apparently has some transitory misgivings himself about his latest offering. This is shown by the title of his opening chapter, "Why Another Book on Nerves?" This question he answers, in part, by pointing out the hundreds of thousands of people who still suffer from "nerves" despite the mountains of information available on the subject.

This book will doubtlessly serve as a comprehensive guide and emotional source book for a good many of the perplexed in our population. It is written in simple, straight-forward, and highly readable language. Like most "cure-yourself" books, it becomes disturbingly hortatory at times, in the best Dale Carnegie tradition. Witness some of the chapter headings: "Your Nerves Are Not as Bad as You Think," "Be Careful You Are

Not Too Engrossed with Yourself," "Turn Your Nerves to Advantage," and "You're Really a Great Guy." This approach will appeal to some readers but will repel many others.

The factual material is for the most part reliable, sound, and clearly presented. At times Dr. Bisch is reassuring to the point of being overoptimistic. He encourages prospective patients to think carefully before rushing blindly to a psychiatrist. He maintains that the vast majority of problems can be cured by the patient himself. If this does not work, he then urges all worriers to consult their family doctor and to let *him* determine whether the problem requires specialized psychiatric help. All this makes good sense—and is a practice which has been advised for many years in most medical circles.

It is difficult, indeed, to make a blanket recommendation for any book intended for the lay public which states on its jacket, "A famous psychiatrist tells you how to help yourself over the emotional maladjustments you can recognize and cure without expensive professional help." No doubt many people will read it and get great comfort. Despite its reassuring tone, I am certain that an equal number will become even more anxious than they were. (I have known patients who were made anxious by reading such supposedly soothing books as Liebman's "Peace of Mind.")

This book is not intended for the true neurotic but rather for the patient suffering from "nerves," whatever that may mean. It would be best for the doctor to know the book (which reads very easily) and his patient (who usually reads too easily!) before recommending it. For the patient who does not mind, or even relishes being talked to like a Dutch uncle, Bisch is just his dish.

ZIGMOND M. LEBENSOHN, M.D.

Breaking Patterns of Defeat. The Effective Readjustment of the Sick Personality. RICHARD L. JENKINS, M.D., Chief of Psychiatric Research, Psychiatry and Neurology Service, Veterans Administration, Washington, D. C. Price, $6.75. Pp. 270. Philadelphia: Lippincott, 1954.

This is a timely book in that we are daily more aware of the effects on our society of the defeated personality and its inability to conform to the larger social pattern. Dr. Jenkins presents a systematic description of a number of life-situations in the child which lead to the development of self-defeating patterns which he carries into adulthood. He shows how these inadequate childhood situations produce today's defeated adolescent and adult who is unable to identify himself with and to orient himself with the larger groups of society. He further shows how, with recognition of the genesis of these patterns of defeat, we can more logically pursue the evaluation, treatment and recovery of the defeated individual.

The author reviews and integrates the elements of various psychiatric schools with his own personal experience, producing a dynamic program of treatment for breaking the patterns of defeat. In doing so he shows in a stimulating way the impact of modern society and of changing family patterns on both the development of and the treatment of these defective living patterns.

This should be an excellent basic book for all who are concerned with the professional care of such maladjusted individuals. It is recommended to the psychiatrist, psychologist, social worker, nurse, and other students of human personality in general.

JOSEPHINE J. BUCHANAN, M.D.

Peptic Ulcer: Pain Patterns, Diagnosis and Medical Treatment. LUCIAN A. SMITH, A.B., M.D., M.S. in Medicine, F.A.C.P., Assistant Professor of Medicine, Mayo Foundation; Head of Section, Division of Medicine, Mayo Clinic; AND ANDREW B. RIVERS, M.A., M.D., M.S. in Medicine, F.A.C.P., Late Associate Professor of Medicine, Mayo Foundation; Consultant, Division of Medicine, Mayo Clinic, Rochester, Minnesota. Foreword by George B. Eusterman. Price, $12.50. Pp. 576. New York: Appleton, 1953.

This book reflects the devoted effort and interest given to delineating the pain patterns in peptic ulcer by Dr. Andrew Rivers, whose untimely death prior to completion of the book cut short a brilliant career. The major feature is the description of the mechanisms of pain in peptic ulcer, the significance of various types of radiation of pain, and the importance in clinical diagnosis of changing pain patterns in clinically suspecting complications of peptic ulcer such as penetration or involvement of other neighboring viscera. While the chapters on anatomy, physiology and treatment are quite adequate, this reviewer believes that the sections on the symptoms and diagnosis of gastric and duodenal ulcer are the outstanding features which make this book valuable to the clinician. These chapters have many simple diagrams which delineate the diverse and varied pain patterns, all of which have meaning to the knowing physician. The text is closely synchronized with the diagrams and illustrations, a factor making for easy reading.

The vast clinical experience of the authors and their associates at the Mayo Clinic is utilized here in an admirable manner to bring to the profession the clinical knowledge in diagnosis and management of an extremely common ailment.

IRVING B. BRICK, M.D.

RALPH MICHAEL LECOMTE, M.D., F.A.C.S.

1888–1954

Dr. Ralph M. LeComte, a Life member of the Medical Society of the District of Columbia, died at Doctors Hospital, March 11, 1954, after a long illness. He resided at 2809 Thirty-fourth Place, N.W., Washington, D. C.

Born February 19, 1888, in Butler, Pennsylvania, Dr. LeComte first came to Washington to enroll as a student in the Georgetown Preparatory School. He subsequently received his medical degree from Georgetown University in 1910 and interned at Providence and Columbia Hospitals. He was microscopist at the Army Medical Museum from 1912 to 1914, and served for a year in World War I. Beginning in 1914 he devoted his practice to urology, serving on the staff of Georgetown, Providence, Sibley, and Suburban Hospitals for over 38 years, until ill health compelled his retirement at the end of 1952. During that period he also served as an instructor in various capacities at Georgetown University School of Medicine, and in 1926 was appointed Professor of Urology.

One of the founders of the Washington Medical Center, which includes the Washington Medical Building, the Columbia Medical Building, and Doctors Hospital, Dr. LeComte served the several corporations as director and in other official capacities over the years.

He was active in a number of medical societies, including the District Medical Society, of which he was an Active member since 1915; he was Chairman of its Executive Committee in 1935–36. He was a member of the American Medical Association, the American Urological Association, the American College of Surgeons, and such local societies as the Galen-Hippocrates Medical Society and the Washington Urological Society. In 1946–47 he was President of the Mid-Atlantic Section of the American Urological Association. During his lifetime he was also a member of the Cosmos Club, the Washington Golf and Country Club, and the Knights of Columbus.

His "Manual of Urology," first published in 1933 by William Wood and Company, went through four editions in English and was translated into Spanish. He also published more than 35 articles in various medical journals.

Surviving him are his wife, Mrs. Violet Page LeComte, and three children: Frederick C. LeComte, living at home; Mrs. Charlotte Jane Casey, of Scranton, Pa.; and Ralph M. LeComte, Jr., of Falls Church, Va.

HERBERT E. MARTYN, M.D.

Carbon Dioxide in Neuroses—Odenwald

(Continued from page 254)

of several patients suffering from epilepsy and suggests use of CO_2 inhalations to ward off attacks.

SUMMARY

The recent literature regarding the use of carbon dioxide in the treatment of neurosis has been reviewed. Over 1,000 patients treated have been reported, with cure or considerable improvement in a large percentage of certain types of cases.

How improvement of these patients is brought about by this treatment is not known, although a number of hypotheses have been suggested. Whatever the physiologic-psychologic therapeutic factor is, it must be agreed that the method is well worth further trial and study.

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PROBLEMS ASSOCIATED WITH THE NATURAL HISTORY OF ESOPHAGEAL VARICES*

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ALTHOUGH it is very difficult to compile valid and clinically useful statistics on the matter, it appears fair to state that hemorrhage from esophageal varices constitutes the most dangerous threat to the patient with cirrhosis. Furthermore, now that the surgical approach is proving so effective in certain instances of severe hemorrhage from ulcer, varices are replacing ulcer as the most common source of fatal gastrointestinal hemorrhage. There is no need to belabor these points. The important consideration is that technics for surgical portal decompression are effective and are now available, and it is incumbent upon the clinician to know about the presence of varices whenever they occur. It is not enough to wait for a hemorrhage before a search for varices is instigated. The first variceal hemorrhage is fatal in approximately half of the cases when the basic disease is portal cirrhosis. In this regard it is important that undue confidence not be placed in improved tamponade technics for emergency control of acute variceal hemorrhage. Even though bleeding can be quickly stopped by local measures, a sudden small hemorrhage in the cirrhotic is frequently sufficient to initiate irreversible liver failure.

The major problem regarding hemorrhage from esophageal varices is created by ignorance of the natural history of portal hypertension and of varices themselves. Formerly it was assumed that varices are rather static things, requiring considerable time for development and remaining unchanged or gradually worsening over the course of time. It was assumed that portal hypertension is a rather static condition, that all of the native portal-systemic collateral systems, including varices, behave in unison without reciprocal functions, and that there is no local mechanism to regulate volume flow through the variceal system. It can readily be appreciated that, should the presence or even the size of varices fluctuate rapidly from time to time under conditions of static liver disease or static portal hypertension, then the indications for surgical portal decompression would have to be revised radically, and means of measuring the effectiveness of the shunting procedures would similarly have to be revaluated. Those who carry out radical operations to decompress the portal system assume a worrisome responsibility in this connection. But even should the natural history of portal hypertension be fully elucidated, one of the most mysterious of questions would remain, namely, the explanation for initiation of variceal hemorrhage.

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All of these matters are under active investigation in many centers throughout the country. The stimulus has been the thoroughly practical one of proper direction of surgical efforts. In the case of esophageal varices, as in so many other fields, the potentialities of the surgical approach have far outstripped clinical understanding. Certain observations made along these lines at three hospitals here in Washington may be of interest.

DIAGNOSIS OF ESOPHAGEAL VARICES IN PORTAL CIRRHOSIS

Physical examination of the patient with portal cirrhosis gives little help in judging whether or not esophageal varices are present. There is only rough correlation between the severity of the basic disease and the existence of varices. Similarly, the severity of the other clinical signs which accompany portal hypertension, splenomegaly, ascites and prominent superficial abdominal venous pattern, does not parallel either the presence or severity of varices. These observations encourage acceptance of two theories which have been applied to portal hypertension: first, that in cirrhosis intrahepatic venous block is due to the recovery process of lobular regeneration, not to the scarring of fibrosis, and second, that there may be a mechanism which provides for reciprocal utilization of the several native portal-systemic venous collateral shunts from time to time. Another important concept, to be mentioned later, is that varices may come and go rather quickly in some patients under conditions of apparently static liver disease. The danger of attempting evaluation of varices by a single examination of the esophagus is thus apparent.

Of the clinical findings which are characteristic of the patient with cirrhosis, the presence of spider angiomata correlates best with the presence of varices. It seems especially significant that it is not the signs of portal hypertension which furnish the closest correlation. Approximately 62 per cent of patients with varices have spiders. Approximately 29 per cent of patients without varices have spiders.

Presumably the examination method which gives the greatest number of positive results in a given group of patients is the most accurate. A study was made of 248 patients proved to have portal cirrhosis by liver biopsy. Varices were found by radiographic examination in 39 and by esophagoscopic examination in 166. In no instance did endoscopic study fail to demonstrate varices that were found by the radiologist. In other words, of patients proved to have varices, the lesions were detected by X-ray examination in only 23 per cent. There is no question that roentgenologic technics are ineffective for demonstration of esophageal varices, and that the direct endoscopic approach is very accurate.

It is clear that the clinician cannot rely on physical findings or, parenthetically, liver function tests, to help in judging the presence of varices, nor can he predict their severity by these indirect methods. Routine utilization of the esophagoscopic method is the only reliable way of evaluating esophageal varices.

SOURCES OF HEMORRHAGE IN THE CIRRHOTIC PATIENT

One of the most critical of diagnostic problems is that presented by the cirrhotic patient during massive hemorrhage. The most dangerous assumption to be made under these conditions is that the patient's hemorrhage is originating from esophageal varices. Cirrhotic patients potentially have other sources of upper gastrointestinal hemorrhage. A source which appears to be a direct complication of portal hypertension is erosive gastritis, an important secondary disease of the cirrhotic which has not been sufficiently publicized. Statistically, duodenal ulcer appears to be a bit more common among cirrhotics than among the population as a whole.

A thorough study was made of 96 proven cirrhotics who had a history of massive hematemesis. There were varices in 80. A total of 57 other potential sources of hemorrhage was found among 41 of the patients. In other words, 17 per cent of these cirrhotics with hemorrhage didn't at the time have varices at all, while, among those that did have varices, 36 per cent had other bleeding lesions. The commonest other lesions were duodenal ulcer, gastric varices, hiatus hernia, gastric ulcer, gastritis, and esophagitis. It is apparent that when the patient with the physical findings of cirrhosis and critical upper gastrointestinal hemorrhage is automatically treated by emergency measures directed at esophageal varices, as by pneumatic tamponade, failure must be expected in an important portion of cases. The odds that such may be the case are rather good. The possible results of misdirected therapy are so serious that it becomes most important that actual search for the bleeding point be initiated as quickly as possible after hemorrhage begins.

Study during active hemorrhage has in most instances proved so revealing that the difficulties of the technic have seemed minor. Briefly, the procedure calls for esophagoscopy, gastroscopy and fluoroscopy, following icewater lavage, quickly after the patient comes under medical surveillance. It is entirely possible to detect the bleeding source soon after hospitalization, even in the face of severe hemorrhage. In some cases local measures carried out transesophagoscopically have been effective in controlling hemorrhage. In fact, of the various bleeding lesions which may be encountered under these circumstances, the most can be accomplished on the spot if varices are found. Injection of sclerosing solution plus pneumatic tamponade probably offers the optimum in emergency treatment for bleeding varices. But accurate diagnosis has much more importance than permitting transoral local treatment. The clinician's primary responsibility in the dangerous situation created by massive hemorrhage in the face of severe liver disease is to see to it that, if radical surgery is done, it is directed at the bleeding lesion. For example, emergency transthoracic varix ligation has been done in more than one patient whose hemorrhage was later proved to be originating from a duodenal ulcer, or emergency gastrectomy performed when varices were causing the bleeding.

NATURAL HISTORY OF VARICES

The concept that the indications for surgical portal decompression, once identified, persist at least as long as the clinical picture remains relatively static no longer appears acceptable. In the past it has appeared physiologically unlikely that there can be important spontaneous alteration in utilization of the various collateral channels under conditions of relatively static portal hypertension. Recent observations suggest otherwise. To be sure, spontaneity of variceal variation cannot be explained at this time. Varices are generally viewed as strictly passive shunting mechanisms, their volume flow and hydrostatic pressure depending on the demands of the portal venous volume. Histologic study of the varix wall does not show enough muscular tissue to suggest independent control of its own diameter. However, because the veins which cross the cardia constitute only one of several native portal-systemic shunting systems, it may well be that they are utilized only reciprocally with the other collateral veins. Thus, local conditions might temporarily discourage venous outflow through the retroperitoneal veins, increasing the burden on other shunting systems.

One of the important correlations to be considered in studying the natural history of esophageal varices is that which may exist between the level of portal hypertension and the severity of varices. This can be studied by serial examinations of the varices of cirrhotic patients, with direct transesophagoscopic mensuration of varix diameter, of the extent of the esophagus involved, and, by needle puncture into the varices, of the pressure within the portal venous system. This was done in the cases of 31 cirrhotic patients. It was found that in the individual patient there is not close correlation between changes in portal venous pressure and changes in varix severity; however, no instance was encountered in which varices became smaller when the pressure increased, nor larger when the pressure fell. When the findings among all the patients were considered, no correlation could be found between a certain portal pressure level and the severity of varices from one subject to the next. It was concluded that enlarging varices are not necessarily an indication of rising portal pressure, that the degree of varix improvement following surgical portal decompression does not necessarily give information about the degree of decompression achieved, and that portal venous pressure cannot be estimated from inspection of varices.

A second important correlation to be made in understanding the natural history of varices is that which exists between varix severity and the simple clinical signs of portal hypertension. If this matter could be thoroughly elucidated, perhaps reciprocal utilization of the various collateral portal-systemic systems might be better understood. The main problem to be faced in studying such reciprocal mechanisms is the fact that, except for prominence of the superficial abdominal venous pattern, there is no physical finding which measures utilization of a single portal-systemic collateral channel. Nevertheless, some important information can be obtained by following changes in varix severity, as measured esophagoscopically, and comparing these with changes in the degree of ascites, splenomegaly and hepatomegaly. This was done in 67 instances of proved cirrhosis. It was found that there was no constant direct or reciprocal relationship between varix severity and these clinical signs. The state of the varices could not be predicted by changes in physical findings. Most important of all, no sense of security as far as varices were concerned could be drawn from an improving clinical situation.

Perhaps the most unexpected observation was that esophageal varices may appear and disappear under conditions of a static clinical picture. Appearance or disappearance was observed during the course of study of 10 patients, and in 3 of these varices were found to disappear, only to return at a later date. These important changes occurred in some patients in the absence of clinical evidence of a progressive or regressive course, change in other physical signs, or variation in severity of liver disease. They were, in these cases, spontaneous and for the most part unaccountable—unaccountable unless one assumes that an intra-abdominal mechanism exists for pressing the gastroesophageal venous connections into use only from time to time Variation in varix volume flow and hydrostatic. pressure may depend only on the demands of the portal venous volume and on alterations in the capacity of the other collateral shunting systems. Neither can be measured at this time. Whatever the reasons may be, spontaneous alterations in the severity of some instances of esophageal varices must be recognized, if proper use is to be made of surgical decompression technics.

Varices in the Absence of Cirrhosis and Portal Vein Obstruction

Portal cirrhosis, schistosomiasis japonica and mansoni, and the several causes for portal vein obstruction are the main diseases responsible for esophageal varices. There are many other far-removed or more generalized diseases which may be accompanied by varices. Expected incidences are poorly understood because esophagoscopic data are not available. Autopsy examination is unreliable for investigation of variceal incidence, and it has already been pointed out that roentgenologic study demonstrates varices in only a fraction of patients found esophagoscopically to be affected.

Study has been made of patients with various diseases other than those ordinarily blamed for varices, and, among others, it was found that varices may accompany simple portal fibrosis, amebic hepatitis, congenital hemolytic icterus, acute virus hepatitis, pregnancy, and chronic heart failure.

Heart failure, in particular, seems unusually significant in this connection. More than half such patients examined esophagoscopically had esophageal varices, and in some cases the lesions were very large and very extensive. These findings during life are not inconsistent with certain autopsy studies, except for the higher incidence. Hemorrhage from esophageal varices must be considered an unusual complication of chronic failure, but half of those which have been discovered in this Washington series presented themselves with hemorrhage, either before or after the varices had been found. The treatment problem presented was a very difficult one.

PROBLEMS FOR THE FUTURE

Demonstration that surgical portal decompression is both feasible and effective has pointed up the seriousness of current ignorance about the natural history of portal hypertension and esophageal varices. It appears fair to state that long-term esophagoscopic observation of patients with various diseases sometimes accompanied by varices will give the most revealing information in this direction. The main hiatus in present understanding has to do with the factors which are responsible for the actual initiation of hemorrhage. This is quite clearly not a simple matter of some critical hydrostatic pressure level within the varix, although this level may have a controlling influence over the severity of the hemorrhage, once it starts. The importance of erosive peptic action on the mucosa overlying the varices, although appearing paramount at the moment, requires critical study. Most important is investigation into the causes of fluctuation of portal hypertension and the mechanisms which control utilization of the varix outlet for drainage of the portal system.

THE CARE OF THE COMMON MOLE

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OF ALL cancers, visible lesions should be most easily controlled, especially those which contrast markedly with surrounding normal tissues. Therefore, the pigmented malignant melanoma of the skin should be a cancer which is discovered early and usually cured. A 20 per cent 5-year survival rate indicates the inaccuracy of such a prediction and suggests a need to search for reasons for such poor results.

A malignant tumor which occurs on a body surface and has a color which contrasts with surrounding normal skin might still be difficult to control, (1) if the characteristics of the initial minute presenting lesion were not well known, (2) if the biology of the tumor was such that widespread involvement occurred before the primary tumor reached macroscopic size, or (3) if treatment as usually carried out was not capable of altering the course of the disease. From our clinical material and from the literature, information was sought in regard to the first of these points. A study of the 5- and 10-year end-results of treatment will yield answers to the latter 2 points, and such will later be undertaken. However, available evidence indicates that adequate surgical removal can control certain melanomata for extended periods of time.

Available Descriptions of Early Malignant Melanoma

Since early malignant melanoma begins in one or a few cells, the beginning will be microscopic. Clinical recognition will be possible only when the lesion has enlarged sufficiently to become visible either within an area of normal (if arising *de novo*) or of pigmented skin (if arising in a pre-existing mole). If untreated, the lesion will progress until it presents the characteristics of malignant melanoma which are described in most textbooks and lectures.

Since surgeons are called upon to treat most melanomas, good clinical descriptions should be included in standard surgical texts if preoperative evaluation is considered a part of surgery. This is especially necessary, since the certified surgeon often regards the removal of small pigmented skin lesions as a chore to be relegated to the least experienced man on a surgical service. Such information is often lacking, even in recently printed textbooks.[1]

The general practitioner and internist are often asked to decide which pigmented skin lesions require treatment which either he himself can carry out or which must be done by a specialist. Good descriptions of such lesions and good rules on which to base decisions are not always given in a standard textbook of medicine. At least one[2] contains no description of the clinical characteristics of a melanoma.

Even in more specialized texts, information may be contradictory and descriptions inadequate. For example, one specialized text[3] clearly indicates that a benign mole cannot always be distinguished from a melanoma by inspection, but goes on to say that "benign lesions under 1 centimeter in diameter are safely removed by electrodesiccation." If the beginning of a malignant melanoma cannot be told from a benign nevus on clinical grounds, how can only "benign" lesions be desiccated or be properly treated in any way which does not include complete microscopic examination?

Recognition of the beginning of the melanoma is also important from the viewpoint of medical economics. The average normal adult has 20 pigmented moles on his skin.[3] The incidence of melanoma in the general population is about 9 in every 500,000 individuals.[4] The removal of every mole, therefore, could not be a feasible method of controlling melanomata; on the other hand, purely from a materialistic point of view, the cost of care of a patient with an incurable melanoma is often high, while that for adequate treatment of a curable one is not.

ILLUSTRATIVE CASES

With these thoughts in mind, case records were reviewed to determine (1) if the average physician can accurately differentiate on clinical grounds between a nevus and the beginning of a melanoma; (2) if a specialist who sees many melanomata can make this differentiation with anything approaching accuracy; (3) if there are any clinical characteristics which identify the beginning of a melanoma; (4) if such clinical criteria for diagnosis of curable melanoma can be stated.

1. *The average physician and specialist does not always recognize the beginning of a melanoma.*

A 25-year-old white man first noted a black mole on his forehead in 1940. It was then the size of a pinhead. Within a period of months it reached the size of a silver dollar. It remained that size until January, 1946 when he bumped that area and subsequently noted ulceration of the lesion. This ulceration was treated as an infection but failed to heal. Later, at another hospital, an enlarged preauricular node on the side of the lesion was removed and found to contain melanoma (malignant). Finally, at still another hospital, the pigmented area was widely excised and the defect covered with a skin graft. On microscopic examination, a typical melanoma was found. Within 2 years the man was dead.

Prior to 1946 it is recorded that at least 16 physicians (including dermatologists, surgeons and radiologists) had examined this lesion. None had recommended treatment even though the patient stated that the lesion was enlarging. One physician definitely recommended no treatment, since he felt that the lesion served as a good identification mark. Two physicians who saw the lesion after ulceration had occurred treated it as an infection. Certainly, in this case, the melanoma became incurable before it was recognized.

2. *The average physician may not be able to distinguish between a malignant melanoma and a benign nevus by physical examination.*

A 20-year-old woman noted a "wart-like" process on the skin of the left abdomen 6 months prior to examination. A brownish red, polypoid mass (2 by 4 mm.) was present; a zone of brownish pigment surrounded its base. The lesion was excised because it was thought to be a melanoma. Microscopically, it was a benign epidermal nevus.

Six months later, the same patient returned because a similar lesion had appeared on the skin of the right lower abdomen. A pedunculated, pink, non-ulcerated lesion (8 mm. in diameter) was present. This was classified as a nevus. Because of its recent origin and doubt as to its histologic structure, excision was done. It was found to be a melanoma. The operative scar was then widely and deeply excised.

This young girl developed 2 skin lesions within a period of 1 year. Both lesions were seen by the same examiner. Descriptions of both lesions are not dissimilar. If either lesion was viewed with more suspicion, it was the first, or benign one. Yet, microscopic examination classified the second lesion as malignant. This clearly illustrates that the exact nature of a pigmented "mole" may not be obvious when it is merely examined clinically.

3. *A specialist may not recognize a melanoma even if it is large.*

A 21-year-old boy had had a pigmented lesion on the skin of his back for 10 years. This had enlarged slowly. His grandfather, a general practitioner, had advised removal. The boy consulted a certified dermatologist who agreed to remove the "mole" in stages by desiccation. Within 3 days of initial treatment innumerable bluish spots appeared on all areas of his skin. A surgeon was immediately called in consultation. He removed both the original lesion and 1 of the minute black spots. On histologic examination, the first was found to be a melanoma, and the small spot an intradermal metastasis. The boy was dead within 4 months.

Certainly, in this instance the specialist first consulted did not realize the nature of the pigmented lesion which he had accepted for treatment.

Numerous additional similar examples could be cited not only from our own experience but from that of other medical institutions which see and treat cancer patients. Therefore, it is imperative that we realize that no clinician can recognize the exact nature of a pigmented skin lesion with anything that remotely approaches an accuracy of 100 per cent; the smaller the lesion the less the degree of accuracy.

Biopsy, particularly with partial excision, is of little value and perhaps may even be harmful. The literature contains many statements which indicate that partial removal of a mole seems dangerous[5, 6] and has been followed by rapid spread of a melanoma if the clinical "mole" contained any such elements.

The following rule must be accepted as true: The accurate diagnosis of any "mole" requires histologic examination of the entire lesion and, therefore, is always made postoperatively and never preoperatively. If "moles" or pigmented skin lesions were as infrequent as breast lumps or solitary thyroid nodules, it would follow that all pigmented skin lesions should be excised. However, this is not practical, since to do this would require the full-time services of at least a majority of the available physicians and medical facilities. Therefore, since all such lesions cannot be removed, indications for removal of a specific pigmented skin lesion must be clearly defined.

As is true of other forms of cancer, there are no symptoms of early melanoma; there are only signs which can be seen or felt. "Itching" of a mole might be an exception to this, but in our experience pruritus limited to 1 mole or even a few moles has not been noted unless some sign of growth was also apparent. If we remember that an accurate diagnosis of a melanoma is possible only postoperatively, any sign which we accept as indicating the possible presence of a melanoma must therefore apply to all moles, each of which must be excised if it exhibits this sign, unless a specific exception can be made. If one does not follow such a policy in excision of pigmented skin lesions, his efforts will be concerned, not with the control of melanoma as a disease, but with other purposes such as the improvement of physical appearance, the relief of mental anguish of the patient, or the betterment of the economic status of the physician. There is no reason to believe that any appreciable number of moles are removed for the pleasure which the surgeon may derive from carrying out the procedure.

Before the signs are listed which will indicate that a pigmented mole should be excised, the term "mole" must be defined. Not all pigmented skin lesions are "moles" if we consider the term synonymous with nevus. Many pigmented skin lesions are never confused with nevi and can be dispensed with as being familiar to all, such as the freckle, the hemangioma, the spider angioma, and the light pigmentation which appears related to or similar to vitiligo. However, a few skin lesions are confused with "moles" or nevi. The most important of these are the seborrheic keratoses, the waxy, raised, multifingered, dark lesions which appear in the older age group, usually in great numbers and generally distributed along skin lines on the back, chest and face. Some of these lesions are deeply pigmented, and although the pigment is exogenous and the appearance usually quite characteristic, an occasional one (especially if single) cannot be classified on clinical characteristics alone, and must be treated as a "mole." Removal of all seborrheic keratoses would create a major problem of its own.

Hereafter, a mole will be considered a pigmented skin lesion which is not obviously a freckle, a hemangioma, an angioma, a patch of vitiligo, or a seborrheic keratosis and therefore cannot be accurately diagnosed by clinical examination alone. The indications for surgical excision of any one of these moles are best considered in terms of permanent and changing characteristics. The significance of anatomic location or associated physiologic or pathologic conditions will be considered later.

The following are indications for surgical excision:

1. *Any mole which bleeds or discharges should be excised.* Such behavior in a benign mole is rare; even if moles occasionally cut in shaving or by a minor injury are included, the total number requiring excision will still be small. On the other hand, a large percentage of malignant melanomata will have bled or discharged prior to surgical excision.

2. *Any mole which is sufficiently frequently irritated to come to the attention of the patient should be excised.* Such moles are relatively uncommon, and all should be excised. Many which occur in an area which is frequently in contact with a part of wearing apparel which supports considerable weight (i. e., shoulder straps) never show signs of irritation and need not be excised unless they do. Often their presence is not known to the patient unless they are within his field of direct vision. On the other hand, proven malignant melanomata will often have shown signs of irritation (i. e., redness, swelling) prior to excision.

3. *Any mole which the patient feels has been enlarging should be excised,* including moles which appear *de novo* in an adult. Most moles change size so slowly that such change is not apparent to the individual or his close associates but may be noted only by someone who has not seen him for a long time. On the other hand, many melanomata have been removed because the patient noted a change in size before excision. There are specific exceptions to this. During pregnancy many or perhaps most moles enlarge somewhat and become more deeply pigmented. Hence, if a patient is pregnant, excisional surgery must include only those moles which the physician thinks are enlarging more than is anticipated as a result of the pregnancy. During the menarche or a period of steroid therapy the same rule must apply, but during these periods recognizable enlargement of moles occurs less frequently.

4. *Any mole which the patient thinks is becoming more deeply pigmented should be excised.* A change in pigmentation of a mole sufficient to come to the attention of an individual occurs infrequently but is noted in the histories of many patients as having preceded excision of a malignant melanoma. Again, there are specific exceptions. During pregnancy, at the menarche, or during a course of hormone therapy increased pigmentation of moles has been noted. Under the latter conditions the change, when noted by the patient, occurs in many or most moles present. At these times, the physician must decide if the changes in any moles are greater than he would have anticipated. Only then should a mole be excised.

Excluding the specific exceptions given, these 4 indications for surgical excision are pertinent each time and for each mole the patient brings to the attention of the physician. The rules do not imply that the physician will personally determine by repeated observation if the mole is growing larger or blacker, or is irritated, discharging or bleeding. In short, these are indications not for "watch and wait" but for surgical excision.

In addition to the signs noted by the patient, there are some which the physician can detect on physical examination. These are related to the color and position of the mole.

5. *A black or blue mole should be excised.* Since most nevi are brown, excision of all black or blue lesions is not a formidable task. Many malignant melanomata when excised are more black than brown in color. The black color is due to the location of the pigment and is seen frequently not only as a characteristic of melanomata but also of junction nevi which histopathologists believe to be the precursors of many malignant melanomata.

6. *A mole on the palms of the hands, soles of the feet, genitalia, the oral mucous membrane, or under the nails should be excised.* Since benign lesions in these areas are relatively infrequent, ex-

cision of each is a practical matter. Almost all such lesions are junction nevi which are considered to be precursors of melanomata. As would be expected, melanomata occur with relatively greater frequency in these areas, a fact which makes the possible yield from such excisions quite significant. There is an exception in the case of the black pigmented areas which occur in the mucous membranes of the mouth. Since these are seen infrequently in the white race, excision is practical and justified. However, in the negro, such areas are seen too frequently to justify excision of each one.

Again, these indications are not for "watching and waiting" but for surgical excision and must apply to all patients. The following are examples of such cases.

A melanoma detected because of its color. A 65-year-old man was examined because of rectal bleeding which was found to be due to hemorrhoids. During the routine physical examination a slightly raised, black lesion was found just within the hairline over the right temporoparietal area. When questioned, the patient recalled its having been there for at least 5 years. Because of its color (black rather than brown), it was excised and proved to be malignant. Further surgery was done.

This lesion was accepted by the patient as a normal part of his anatomy. Detection was possible only because a competent examiner thought the color of the mole to be similar to that of many melanomata which he had seen previously.

The use of these indications for surgical excision of nevi will throw a great but not unbearable load on physicians. These indications for surgical excision have been followed in our cancer detection clinic for several years. During a 12-month period, about 1,400 well patients were examined. Moles were found which required excision in 65 patients, an incidence of about 5 per cent. During a similar 12-month period a total of 1,500 patients with definite complaints were examined in our cancer diagnostic clinic. The same indications were employed, and 106 patients were advised to have at least 1 mole excised. Using these figures as a rough index, the total excisions required in 1 year per 100,000 population would be about 5,000. This number can be handled, but is still quite large. The number should decrease in later years if the policy is widely accepted.

In the case of the cancer diagnostic clinic patients, information is available as to the incidence of unsuspected melanomata which were discovered following excision, namely, 2 in a total of 106 excisions performed in a 12-month period. During the same period 33 junction nevi were excised. Assuming that the prognosis will be better because the excised melanomata were small and that the junction nevi removed may, in a few instances, have represented lesions which would have become melanomata, some benefit was obtained from this type of therapy.

Again we emphasize that all pigmented skin lesions must be surgically excised and not destroyed since only thus can an accurate diagnosis be made. The amount of surrounding normal skin and tissue which must be removed with the mole is also important. Those who believe that a single episode of trauma can cause metastasis from a melanoma must widely excise all suspicious lesions. Few surgeons will do this. A better policy is to excise all pigmented lesions by placing skin incisions about 0.5 cm. from the borders of the lesion; the excision site of those later proven to be malignant melanomata can then be reëxcised very widely with or without a concomitant regional lymph node dissection.

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WHEN SHOULD THE PHYSICIAN REFER A PATIENT TO A PSYCHIATRIST?*

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TO WHAT extent should the general practitioner himself handle the psychiatric difficulties which he sees in his patients and to what extent should he refer them to the specialist in psychiatry? In some ways this is a familiar enough kind of problem, one you must meet very frequently in your dealings with the multitudinous and diversified ills which your patients present.

I suppose that all of you do certain kinds of minor surgery, such as evacuating furuncles, or at least removing splinters, and at the other end of the scale you would all refer to a surgical specialist a case requiring partial pancreatectomy or extensive skin-grafting following a severe burn. In the same way you would have no trouble making the decision that a panicky, actively hallucinated and delusional psychotic should see a psychiatrist; nor, unless you were no longer interested in making a living in medicine, would you turn from the doors of your consulting rooms every patient whose symptomatology was based to any degree on emotional conflict. Thus, in both the psychiatric and the surgical spheres, there are cases which you know you can and should take care of, and there are others which quite obviously must be referred. Similarly in both instances there is an intermediate group of indeterminate size in which the disposition is a matter of individual judgment.

However, the fact that I have been asked to talk to you on this topic, which would hardly require extended elucidation if we were discussing surgery, is indicative of the special difficulties and obscurities adhering to the question of psychiatric referral. There are a number of reasons for this state of affairs, among them the fact that the material being dealt with is usually subtle and complex rathet than obvious, the all-pervasive quality of the emotional components of illness, the uncertainty as to what the psychiatrist does and just how much he can be expected to accomplish, as well as certain overt and covert attitudes toward psychiatry and psychiatrists on the part of many practitioners.

It is neither possible nor, I think, desirable to reduce the problem to a set of absolute rules. Talents and skills vary, and a case in a particular area of medical practice which might prove to be compelling and rewarding to one man may be of little interest to another. There are, however, a number of considerations which should be taken into account when you are in doubt as to whether to treat a patient yourself or to refer him to a psychiatric specialist, and I believe it may be helpful to enumerate and discuss some of these.

In general, they may be divided into two sets of factors, those having to do primarily with the patient and those primarily involving the physician himself.

FACTORS RELATING PRIMARILY TO THE PATIENT

The patient's own attitudes and wishes about seeing a psychiatrist. To dragoon an individual into consulting a specialist against his expressed desires is to assume a rather heavy responsibility, especially since an awareness of the existence of difficulties in living and some urgency to do something about them are important prerequisites for successful psychotherapy. At the same time, one should not take every patient's protestations quite at their face value. Despite a public relations job of unparalleled dimensions, there is still some stigma attached to being treated by a psychiatrist, and the patient's objections may be simply a conventional obeisance to this attitude, which can be removed by the advice and explanations of a trusted and respected physician. Or these objections may represent feelings of fear or hopelessness in a person really desperately desirous of being made to feel that there is a chance that he can be helped. One might summarize here that except in cases of overriding emergency it is unwise to attempt to force a really unwilling patient to consult a psychiatrist but that it is in the interests of the patient to investigate the reasons for his objections.

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The patient's endowments and actual life situation. In each case, in addition to a consideration of the particular kind of problem the patient presents, an attempt should be made to assess as realistically as possible the patient's actual life situation and his individual endowments or lack of them. Psychiatric treatment is unfortunately sometimes prolonged and expensive, and in certain instances it may be possible to estimate whether or not the chances of substantial improvement are sufficiently great to warrant the attempt. Thus, of two individuals with symptomatically rather similar obsessive-compulsive psychoneuroses, one may be in his twenties, with a good educational background and of excellent intelligence, while the other may be middle-aged, with little education, and rather poorly endowed intellectually. It is probable that the ability to profit by psychotherapy would be greater in the case of the former than the latter, and this factor should be taken into account in making the decision as to whether the patient should be referred. Similarly, a person who has shown a reasonable degree of elasticity in dealing with the various slings and arrows of his particular fortune is a better candidate than one whose adaptability has been conspicuously poor.

A reasonably wide range of emotional responses, some imaginativeness, and the ability to look at oneself objectively are factors which make the chances of success under psychiatric treatment more hopeful as opposed to intense emotional constriction, extreme literal-mindedness, and an inability to be objectively introspective. Although this latter group of unfavorable circumstances may tip the balance against referral in cases otherwise doubtful, they should not of themselves be of determining importance, since they may be modifiable neurotic defenses rather than relatively fixed features of temperament.

Certain features of the patient's current life situation will be of obvious importance in determining whether it will be worthwhile to recommend that he see a psychiatrist. These include the attitude of his family, which may range from the sympathetic and encouraging to the intolerant and derisive, whether his job or home restrictions will permit regular visits, and whether he lives in a locality in which competent psychiatric help is available. Although the patient's financial status should not influence the decision as to whether or not he is in need of specialized psychiatric assistance, a knowledge of this will be of importance in determining whether he be referred to private or clinic facilities.

A factor of particular pertinence is the degree to which the patient's emotional difficulties represent an acute reaction to specific external factors in his environment rather than a slowly developing alteration in, or accentuation of personality characteristics. The latter is almost always a task for the long-term methods of the specialist, while the former may be effectively attacked by relatively superficial psychotherapy combined with environmental manipulation in the hands of the family physician.

The nature and severity of the patient's difficulties. There are certain disorders which require psychiatric referral just as unequivocally as a case of ruptured peptic ulcer requires treatment by a qualified surgeon. In these cases the considerations discussed under the previous heading are of no importance and should be disregarded.

The first of these conditions is any psychotic reaction in which the patient's mental competency is in question, with the exception only of certain transient delirious or confusional states incident to an obvious infectious or toxic process. Such reactions include most importantly schizophrenic states, but also manic depressive and involutional psychoses and organic illnesses such as neurosyphilis, and senile and arteriosclerotic psychoses.

The other condition which should always be referred is any depression, psychotic or psychoneurotic, in which there is suicidal risk. The problems of management and disposition in these cases along with the possible necessity of certain legal actions, such as commitment, entail responsibilities which should be assumed only by a qualified psychiatric specialist.

In patients who fall into either of the two categories described above, the difficulty that the practitioner will find is not what to do with them but rather how to recognize them. The subtle paranoid or the masked depression are diagnostic problems whose detection requires skill and acumen equal to that necessary in any other medical field.

Although it is not within the scope of this paper to cover diagnostic considerations in detail, I should like to mention some danger signs which should be kept in mind. In the direction of loss of mental competency—and here I am dealing particularly with developing schizophrenic psychoses—one should be alert to early distortions of reality and to difficulties in communication with the patient.

Distortions of reality may first manifest themselves as beliefs on the part of the patient that there is something rather strangely unique about himself, that events in the world are meant to have a special significance for him, that apparently irrelevant actions of people (particularly those of the doctor) are really being performed with his own welfare or destruction as their purpose. This is often accompanied by feelings of unsureness and perplexity which, as the psychosis crystallizes, are frequently suddenly and dramatically succeeded by a conviction that what he has been suspecting is really so.

By difficulties in communication I am referring to the various ways in which the doctor gets to feel that a conversation with his patient has somehow been unsatisfactory and has left him with a feeling of strangeness and puzzlement. He may find that the patient and he have been talking at cross purposes, that the conversation although apparently sensible has really been a verbal fencing match without real communication, that the replies to his questions are just a little bit tangential and somehow miss the mark.

The risk of suicide should be taken seriously in any patient with a deep and persistent mood of depression which is worse in the early mornings, especially when accompanied by loss of appetite and sexual desire and feelings of unreality. When there are also severe insomnia and mounting sensations of tension, the danger is grave, and the occurrence of these symptoms should alert the physician to the possibility that he is dealing with a severe depression even when the depressive affect is concealed behind vague somatic complaints or feelings of emotional emptiness.

I would like to voice a warning concerning the statement often made about suicide that "those who talk about it don't do it." In a matter as serious as possible self-destruction it is unwise to rely on a cliché, and although there may be some statistical support for the assertion, statistics will prove cold comfort if your patient proves to be one of the frequent exceptions.

The group of patients who consult the physician primarily because of clearly psychoneurotic symptoms are properly in the province of the psychiatric specialist and if possible should be referred to him for treatment. However, this generalization does not apply with equal force to all varieties of psychoneurosis. Patients who complain of phobias, obsessive thoughts, compulsive behavior, or long-standing depression almost always require prolonged therapy of a kind which the general physician is not equipped to give. This is also true of chronic anxiety states or anxiety attacks without apparent situational precipitation, whereas acute anxiety or "nervousness" directly related to factors in the patient's environment may be adequately handled by the family doctor in individual instances. In conversion hysteria, methods available to the nonspecialist can sometimes bring about a symptomatic cure, whereas if the decision is to attempt to effect a change in the characterologic structure underlying the particular manifestation, specialist treatment will be necessary. It is in many of these psychoneurotic disorders that the considerations adduced in the previous section, that is, the patient's ability to profit and his actual life situation, will have particular weight. No matter what his decision, however, I believe it wise for the physician to secure psychiatric consultation in these cases both for confirmation of his opinion and for help in his treatment plan if he is to handle the case himself.

The problem of whether or not to refer to a psychiatrist patients suffering primarily from psychosomatic illness, although in some ways similar to the problem of the psychoneurotic, has complicating features not found with the latter. The first of these is the fact that the psychosomatic patient, unlike the phobic or obsessive, may have little or no awareness that emotional components play a role in his disorder. Thus the suggestion that he see a psychiatrist, in cases in which this is felt to be advisable, may be very difficult for him to accept. It is here that the physician can render his patient a great service by creating an atmosphere in which psychiatric referral comes to be the logical and inevitable step rather than something incomprehensible or disgraceful.

The second factor special to the group of psychosomatic illnesses is that here it is often not so much a question of either the general physician or the psychiatrist but rather of a collaboration between the two. This is not always true, of course. The patient who develops a headache in certain situations or who suffers from premature ejaculation can be turned over to the psychiatrist in a definitive manner once an adequate organic investigation has proved negative. But in cases with undoubted organic components, such as peptic ulcer or ulcerative colitis or bronchial asthma, the physician cannot refer the patient to a psychiatrist and then drop out of the case. Rather, the closer the collaboration between the two, the more fruitful the therapeutic results are likely to be.

When and at what point the help of the psychiatric specialist should be called for is not something which can be put into rules, although it may be well to remind you that equally to be avoided are both excessive study to find nonexistent organic causes as well as too quick referral in the mistaken notion that every obscure complaint must be psychogenic. In general, if a patient with a disorder such as those mentioned above, which are known to bear a close connection with the emotional life, has failed to respond to conventional remedies after an adequate trial, and, if the attending physician is able to see correlations between changes in symptoms and events in the life of the patient, the addition of psychotherapy to the treatment program is in the best interests of the patient. The previously discussed factors of ability to profit from psychiatric help and the nature of the life situation will also play a role in the decision as to which psychosomatic patients are to be handled without specialist assistance.

FACTORS RELATING PRIMARILY TO THE PHYSICIAN

Education, training and interest in psychiatry. A physician who has gone to a medical school with a good course in psychiatry, especially its dynamic aspects, who has continued to read articles and books on the subject and even possibly attend symposia such as this, and who has maintained a lively interest in, and curiosity about what makes people behave as they do, will inevitably find himself dealing with a larger segment of the emotional problems of his patients than will his colleague with a different background and attributes. The former will have a more realistic idea of what psychiatrists are able to accomplish, and he will be in a better position to note in his patients danger signals which indicate that he is getting beyond his depth.

As in any other field of medicine, the more you know about a subject and the greater your interest in it, the keener will be your diagnostic acumen. Conversely, the doctor who knows little and cares less about psychiatry and the emotional aspects of his patient's difficulties will run the risk of either failing to recognize potentially serious problems or of trying to handle them himself to the detriment of his patients.

The attitude of the physician toward the patient. A physician should not attempt to deal directly with the emotional problems of a patient for whom he has strong feelings of dislike and lack of respect. Most people with difficulties in living, whatever their symptomatic expression, have fragile and vulnerable feelings of self-esteem. When such an individual makes the discovery that he is viewed with something like contempt by the person to whom he is confiding his intimate secrets, the effect can be a devastating one. I say "when" instead of "if" advisedly, because, in the delicately balanced interpersonal situation which comes into existence whenever psychotherapy of any kind is undertaken, such feelings on the part of the doctor will inevitably make themselves felt. Thus, unless he is able by self-exploration to achieve some understanding of why he feels as he does with a resultant development of tolerance toward the patient, the physician should refer him elsewhere for any needed psychotherapeutic management.

The physician's emotional make-up. There remains as an important determinant the emotional make-up of the physician himself, his personality assets and limitations. In my opinion the most important factor determining successful psychotherapeutic management is the degree of self-knowledge of the therapist—his understanding of what kind of a person he is, how he operates under various conditions, how he is affected by other people, and in what areas lie the weaknesses which when touched upon produce anxiety. Whether such an awareness has been the end-result of a fortunate combination of good native endowment and favorable developmental circumstances or has come about only after a painful struggle with one's own difficulties is much less important than the fact that it is present, since attempting to understand the nuances of behavior of another person without understanding oneself and the meaning of one's reactions to what the other is doing is like trying to tell the atmospheric pressure without a reliable barometer.

Just as an alert self-awareness enables the physician both to handle a wider range of psychiatric problems and to recognize his limitations, so its absence will not only diminish his capacities in this field but also possibly tempt him into dealing with problems which should be in the hands of the specialist. This latter unfortunate eventuality will be especially likely to occur if the doctor has unconscious needs to be omnipotent which can be satisfied by an authoritarian manipulation of the patient rationalized as psychotherapy.

Thus, the question as to whether you should refer a particular patient to a psychiatrist or treat him yourself depends not only on what kind of a person he is and what is the matter with him but also on what kind of a person you are.

I should like to close with the thought that just because we are dealing with emotional problems does not mean that they have to be handled emotionally. The question of psychiatric referral certainly involves considerations different from those in other fields of medicine, but there are criteria available which can result in a reasonably objective and realistic evaluation of the situation and in a decision which will be the one most helpful to your patient.

WHY SOME DOCTORS TAKE DOPE

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THE American public is opening its eyes to the dope menace. We abhor the crime stories of teen-age youth having marijuana parties then hot-rodding down our highways at 80 per. We shudder at the thought of some "pusher" seducing our sons and daughters into houses of ill-fame.

But all too often the man nearest the narcotic needle overlooks the menace in his own little black medical bag.

Dr. Harris Isbell, Director of the U. S. Public Health Service Hospital in Lexington, Kentucky, the Nation's leading treatment center for addiction, says, "Scarcely a week passes that a physician who is a Demerol addict is not admitted to our institution." (Since Demerol made its appearance most new physician addicts take to it rather than morphine.)

If you personally feel secure against narcotic addiction, and think that it is only some worthless no-account with no brains and no future in medicine who takes to the needle, then listen to this case:

Dr. Bishop, as we will call him, was one of the most brilliant students in his class. He graduated *magna cum laude,* took a residency and research fellowship with one of the Nation's leading scientists.

Under the stress and strain of postgraduate study he became tense and overwrought. Finding no time for exercise or breathing spells between tedious hours in the laboratory, he started taking barbiturates in order to get his rest at night. But these didn't do the job.

One night he decided to try a little Demerol. It worked swell. He swooned off into a wonderful sleep, relaxed completely. No worries about insomnia that night.

The doctor had found just what he needed. He had easy access to the drugs in the laboratory, and soon was taking more and more. It wasn't long until he was discovered, and was immediately discharged from his fellowship.

He set up practice in a small town, where he failed miserably because he continued to take narcotics. He is in an institution today.

His loss is the tragic loss of any doctor who becomes a dope—he must renounce his long years of education for the world's most honored profession, a brilliant future, money, prestige. But worst of all, the world lost a doctor and gained a patient.

Here is the heartbreaking story of another gifted physician:

"After my internship I settled in an Eastern city. The war came along, and I was declared essential for civilian practice. From the first my business boomed. Going night and day, I would come home so tired and tense that sleep was impossible. I began taking Nembutal capsules, but they took too long to work. To speed things up I filled a syringe with IV Nembutal and slipped it into my vein. Before I hit the bed I was asleep. Impossible as this may sound, I thought it was smart. Just look at all the time I was saving getting to sleep. Imagine a doctor thinking like that!"

"But how did you start on Demerol?" I asked.

"One evening I came home tired out. My back was aching, my feet were sore and swollen. But I had promised my little 15-year-old daughter I'd take her roller-skating. I was sure I wouldn't be able to put on a pair of skates if I didn't do something for the pain. Surreptitiously I went into the bedroom, took a vial of Demerol from my bag, and gave myself a shot. I went skating and felt swell; in fact, I never had a better time.

"That started me off. I had found an escape from my pain and fatigue. But I little realized that I was falling through a trap door into hell."

If you think the cases of doctors taking dope are few and far between, look at one Eastern hospital, where a regular epidemic occurred. The interns at this institution were taking to dope as ducks to water. Within the space of a few years no less than 5 interns ended up dope addicts. Two died tragically, 1 addicted his wife, 1 has partially recovered.

Even professors and deans of medical schools—the shining examples to students—are today succumbing to this insidious "disease." Take the case of Dr. X.

Although he was dean of a university medical school, Dr. X didn't operate from an ivory tower. He took an active part in its experimental work. He had been studying pain-killing agents in an effort to find the human pain threshold. Sometimes he made tests on himself, using drugs in the experiments. The outcome was that not long ago Dr. X voluntarily entered the U. S. Public Health Service Hospital at Lexington, Kentucky.

One of his colleagues at the university said, "Nobody will ever know exactly what caused the addiction, but Dr. X's close association with drugs may have had something to do with it."

Of course, all physician addicts are individuals, and their stories concerning the onset of addiction are different, but there are three common patterns into which physician addicts fall. According to Dr. Isbell these are:

1. Alcoholic physicians who relieve hangovers with opiates.
2. Tired doctors who habitually blot out fatigue with a narcotic.
3. Doctors suffering pain from disease, who overdose themselves with opiates.

The alcoholic physician who finds it difficult to carry on his practice the day after a debauch may be given or he may take an opiate, which relieves all the symptoms of his hangover—the mental dullness, headache, nausea, or gastric pain. This he falls back on periodically. Finally he begins to take the opiate instead of the alcohol. Then the doctor is a dope!

The overly fatigued physician is all too common. He loses sleep several nights, receives another call, which he feels he cannot make without a "stimulant" to keep him going. He takes a dose of morphine, methadone, or Demerol, and goes ahead and makes his call. Finding such an escape a great relief he repeats it, until he too falls through the trap door into addiction.

The doctor who develops a painful disease, usually chronic in nature, is another candidate for addiction. He is given an opiate for relief of pain or after an operation. He returns to work too early, still has pain, continues the drug, until he is chained as a narcotic addict.

These common patterns seem to be excuses for the beginning of narcotic addiction, but Dr. Isbell points out that "we always find a serious emotional disorder in the background which leads to addiction."

The emotional upset may be anything from a marital rift to income-tax trouble. What every physician must remember is that he is human. Even though in his bag is an escape through a needle, he must never allow himself the pleasure of using it. For that narcotic in his bag is like a veritable serpent in Eden, which can lead only to his being thrown out of the Garden of his profession.

The course after the onset of addiction varies. Alcoholics who change to opiates usually give up the alcohol, and for a time their adjustment and social productivity appear to improve. But in the end those who use Demerol have even greater impairment of their ability to work than those who use alcohol.

Ordinarily the physician addict tries to cover his addiction by charging off to various patients the narcotics he is taking. His increase in the narcotics prescriptions leads to an investigation by the narcotic agent. The doctor then tries a "cure" in a private sanitarium. He will succeed in getting off narcotics, but ordinarily he returns to his practice much too soon, and promptly relapses. His relapse is usually due to the emotional disorder that led to the addiction in the first place.

By now he is in trouble with the narcotic agents and his medical society. He loses his narcotic license and his license to practice medicine. He turns voluntarily to one of the Federal hospitals for narcotic addiction, at Lexington, Kentucky, and Fort Worth, Texas.

The percentage of relapses, even after Federal Public Health hospital rehabilitation, is not available, but it can be stated categorically that a very large number of physician addicts relapse time and again, just as other addicts do. The reason: They are human. They are susceptible to the same emotional stresses and strains, only more so, that their patients suffer. As every doctor knows, the worst patient he can ever have is another physician.

What most physicians need is a good night's sleep, more vacation time, release from tension, a quiet place for meditation. Yet few of us are willing to take time from a busy practice. When a person gets wound up tight nervously he may do a lot of reckless things. Even a doctor is not immune to the temptations that lure the layman in search of nervous release. In fact, a physician is in greater danger than any layman, because of the tense, tiring life he lives, and because of his easy access to the drugs.

Yet little or no instruction on narcotic dangers is given among physicians or in medical schools. It is high time that medical schools begin telling students the dangers and pitfalls they will face once they get a narcotic license, and have easy access to morphine, Demerol, codeine, and the other narcotic drugs.

The outstanding feature of these cases of physician addicts appeared to be a lack of warning of young doctors before they went out to practice.

One addict told me, "During my student days not a single professor told us a word about narcotic addiction. We had plenty of lectures on how to prescribe narcotics, but not a word on the personal dangers—the hell on earth that comes after a doctor takes his first dose.

"We were warned repeatedly to stop narcotics two or three days postoperatively. However, not a word of warning was sounded about what would happen if the doctor took them for an aching back or painful joints when he had to keep going.

"It's time professors of medicine stopped taking for granted that young, inexperienced medical students know everything they should know. They should warn them of the dangers. These young men ought to know about tragic cases such as mine. They are immature. Their knowledge is still spotty. They can't realize how much they still have to learn. It takes a lot of living to become aware of all the pitfalls of life."

This matter of warning against the perils in easy access to drugs is a point every medical student and intern should have drummed into his very being. Even tavern owners tell their bartenders that their period of usefulness ceases the instant they start drinking liquor themselves.

Warnings evidently had not been sounded at a California hospital where an intern was discovered who knew how much "fun" a Demerol jag was. He had started a resident to taking it also, and before long they had drawn a nurse into their little party. Not until horrified hospital authorities found out what was going on were they out of danger.

Then not realizing the jeopardy to other interns and residents, the authorities hushed the matter up, and in spite of their sad experience they never gave a single medical student, nurse, or hospital doctor a word of admonition before sending him on the hospital floor.

Naturally every medical institution must guard its reputation. But if it values its reputation deeply enough it will adequately instruct its personnel for their own safety and for the safety of the patients.

It is time every doctor—you and me—and every medical student—be told the "facts of life" when it comes to narcotic addiction.

Another solemn word of caution given by the

U. S. Treasury narcotic T-men is:

Doctor, don't be a dope peddler! You'll get caught every time.

One unfortunate doctor in a western state tragically learned this fact. He had been playing the races and lost heavily. In debt, he needed money quickly. A dope addict was tipped off to the doctor's plight. He stopped by the doctor's office, offered him $25 for a prescription for Demerol. This was not enough. The addict upped it to $100, and the doctor saw the answer to his indebtedness.

After he had written several $100 prescriptions, a dope peddler stopped in at his office to warn him that if he didn't write a "big" prescription for him he'd be turned in for treating the addict without notifying the authorities. The doctor was in a corner. He wrote the prescription for a large number of tablets, and within hours was picked up by the T-men.

His narcotic license was immediately revoked, he was disgraced in his community by newspaper publicity and had to leave town. His only comment to the T-men: "Oh, what a dope I was!"

So even if you don't take the stuff yourself, doctor, don't be a dope!

To avoid this insidious "disease," remember:

1. You are human, subject to the temptations of laymen.
2. Never let easy access to narcotics be an excuse for your first "shot."
3. Don't get overly tired and fatigued. When you are worn out, take a vacation. It's a lot safer, and a lot more fun.
4. Don't drink. Alcoholism can lead to drug addiction.
5. If you have surgery or get sick, don't ever take narcotics on your own. Keep in mind what Benjamin Franklin said: "The man who treats himself has a fool for a doctor."
6. As a monitor against easy escape from an emotional problem, always think of your family, your future, and your prestige. Best of all, breathe a prayer for God to keep your hand off any narcotic during time of stress.
7. Take time to relax each day and meditate on the many blessings God has given you. This will "up" your spirits. Only depressed doctors take dope. Keep a happy mental outlook, and you do much to prevent the world's most insidious and most hopeless habit.

Doctor, don't take dope!

THE OBSESSIVE-COMPULSIVE NEUROSES*

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DYNAMICS AND PATHOGENESIS OF OBSESSIVE-COMPULSIVE DEFENSES

THROUGH careful study and observation it has become possible to correlate many events in infancy and early childhood with later personality traits and neurotic symptoms. Many of these relationships have been considered earlier. In the development of the obsessive defenses those events surrounding the establishment of bowel habit training may play an important role. Often intensive study will indicate increased relative importance attached to this period of psychologic development. Part of the significance which is normally later attached to genital areas and function may remain at this lower level. Expressed more technically, anal erotism may partially replace genital erotism.

Where parents are themselves secure and do not become overconcerned at the time of training, there is apt to be little difficulty and these events do not then have undue significance attached to them. Where the mother is anxious, the story is quite different. The child intuitively senses the parental emotional response to variations in function. Delay or refusal makes mother concerned.

Somewhat magically, feces to the infant can equate a valuable gift or a weapon. In the latter sense the primordial mechanism can develop for control, power, and retaliation. This of course is inoperable in a void. The parent inevitably contributes to this according to his response, the amount of anxiety and concern evoked. In other words, the endeavor must be responded to, to make it profitable and to encourage later development of patterns of behavior based upon these infantile ones. This can be a powerful lever in the hands of the infant over an otherwise seemingly omnipotent figure. The child would have to be very undiscerning and obtuse not to recognize this. He would have to be very mature (and of course he cannot be) not to make use of it. With many obsessional patients data are forthcoming to confirm some phase or other of our information about the important possible effects of this early period. The following is a verbatim extract from a recent analytic hour with a patient well along in treatment for a moderately severe obsessional character structure.

Case 7. "A great deal of attention was paid to my habits of elimination in the early years, especially by my mother. She was very concerned about my bowel movements. She believed that health was dependent upon elimination, that these were poisons. She would become anxious if I had no movement and relieved if I had. If my bowels moved to her satisfaction then everything would be all right! . . ."

The mechanism for possible control here is quite apparent from the response of mother. The patient went on to indicate his own perhaps inevitably heightened interest in this function. "Sometimes bowel movements were pleasant and I would enjoy them. I am reluctant to discuss this and as I do so I feel tension and tightening in my lower abdomen. I must regard it as somehow wrong that I took so much interest in elimination. Sometimes movements were uncomfortable. It all depended on the amount of my retention, which would always get a rise out of mother. . . . She seemed very powerful to me all right but this was part of me she couldn't control. I guess this was a way I could sometimes turn the tables." In this patient's presentation we must note the careful phrasing. This is characteristic of one type of obsessional control of feelings. There is an outward academic facade with the divorcement of inner affect from outward appearance. The reported bodily sensations help point up this discrepancy of subjective affect and outward expression.

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* This paper was presented in connection with postgraduate medical teaching programs in psychiatry to the Department of Neuropsychiatry, Walter Reed Army Hospital, Washington, D. C., April 8 and 15, 1954; to psychiatric Residents-in-training, St. Elizabeths Hospital, Washington D. C., March 30 and April 6, 1954; and, in part, to the Resident Staff, Surburban Hospital, Bethesda, Md., March 18, 1954.

This, the eighth article in a series by Dr. Laughlin covering the psychoneuroses, is being published in two parts, of which this is Part II. The next article, entitled "Fear and Phobias," will appear in the July issue of the MEDICAL ANNALS.

The entire series will be included in a forthcoming psychiatric text entitled, "The Neuroses," which will be published early in 1955 by W. B. Saunders Co., Philadelphia, Pa.

Patients with obsessive defenses have a reduced capacity for love and affection. As we saw earlier, the control demanded by parents, particularly during the years from 6 to 10, developed inhibitions which tended to limit most spontaneous expression. During these years there was likely an overemphasis by parents for control, performance, independence, maturity, orderliness, and the abandonment of childishness. Lorand[14] pointed out a possible contrasting overdulgence and attentiveness during the preceding anal phase of development which he regarded as significant. Predisposing factors to the development of obsessive defenses include:

1. Parental insecurity.
2. Underlying rejection of the child, with the struggle of the parent at concealment resulting in outwardly unreliable and ambivalent attitudes.
3. Parental overambitiousness for the child's success and maturity.
4. Early overindulgence and tacit encouragement of dependence, succeeded by later stringent demands for responsibility and maturity.
5. Obsessive traits in the parents often tend to encourage (consciously or unconsciously) or to place a premium upon the development of similar traits in the child.
6. Parental, social, or religious condemnation of negative feelings; rejection of spontaneous demonstrations of affection.
7. The social and cultural premiums placed on obsessive traits (e.g., even income-tax laws contribute in view of the required interest of the citizen in maintaining some kind of records and books).

Freud[15] early noted the connection of obsessive symptoms with repressed memories; "... their symptoms arise through the psychical mechanism of (unconscious) defense, that is, through an attempt to repress an intolerable idea which was in painful opposition to the patient's ego."

The underlying psychopathologic sadistic satisfactions which are obtained secretly (out-of conscious awareness) by the obsessional are similar to what we observed in our study of depression. Freud[16] excellently pointed this out in succinct fashion in his paper "Mourning and Melancholia" when he said, "... the corresponding phenomenon (the self-torments) in the obsessional neurosis signifies a gratification of sadistic tendencies and of hate turned around upon the self. In both disorders the sufferers usually succeed in the end in taking revenge, by the circuitous path of self-punishment, on the original objects and in tormenting them by means of the illness, having developed the latter so as to avoid the necessity of openly expressing their hostility against the loved ones." The reader must bear in mind that this is part of the endogain, i.e., the deeply buried primary purpose of the emotional sickness. It remains completely hidden from conscious awareness, except upon successful therapeutic intervention.

The seemingly insoluble dilemma of the obsessional lies in the fact that his unconscious hostility, rivalry, destructive impulses, and aggression are directed toward the very figures upon which he is vitally dependent. The frustrating and demanding parents are simultaneously the objects of love and dependency. Tremendous ambivalence inevitably develops. It is no wonder that guilt and anxiety are intense both now and in later interpersonal relations. Symptoms develop in the service of denial, control, or concealment of unacceptable banished hostile (also sexual) impulses, as will be seen in the next case. "The meaning of this becomes clearer when the observation is made by psychoanalytic investigation that the obsessive-compulsive symptom, which aims at the protection of the patient and his parents or others in authority, actually arises from destructive wishes toward them—those in authority."[10]

We may understand this more clearly perhaps if we can recognize that to the infant, destructive wishes may rather magically approach actual fact. Anger toward the parental figure jeopardizes security: the food, warmth and love so vital to the infant—his very survival. In other words, anger threatens the source of supply. Thus the dilemma mentioned above. The only safeguard is total rejection (repression) of such dangerous thoughts.

Anger toward parental figures is also dangerous because of possible destructive retaliation. The infant may fear that any destructive impulses toward these powerful omnipotent figures may be reciprocated. Weight may be added to this fear if the child senses by intuition some real rejection by one or both parents. This then is an additional force helping to restrict all expression of any hostile nature or even awareness thereof.

The intense need of the obsessional in later life to be pleasant, to appear friendly at all costs, becomes more understandable. He has a tremendous need to be acceptable. Anger equates disaster!

Symptoms may develop in the person with an obsessive diathesis at any juncture when these disowned (repressed) impulses threaten to come into conscious awareness. This may occur when existing defenses break down or prove inadequate. Despite the fact that the obsessive idea may be quite painful in itself, it helps prevent something much more unbearable to the patient. Let us consider briefly a point or so concerning the dynamics present in the following example:

Case 8. The patient, a young housewife, was treated briefly by her physician for insomnia, digestive disturbances, and nervousness. Referral was made when she told him the basis for her disturbance lay in her unreasonable and senseless but recurrent doubts about her husband's state of love for her.

When first seen she appeared worried and depressed as she discussed her struggle in attempting to banish the unwelcome and "inane" doubts which kept recurring. She went into endless detail to establish the absence of such a possibility. In explaining how impossible this was, I was told that never a cross word or disagreement had passed during 8 years of what was pictured as the ideal of marital bliss. To her, marital bliss was apparently equated with an absence of the slightest negative feeling. When husband and wife were seen together it seemed as if the wife had to go out of her way in the use of endearing terms. The husband was troubled and mystified by his wife's illness and in turn went to endless pains to reassure his wife, part of which consisted in his trying to behave as an ideal lover whose only interest in life was his wife.

As suspected from the early interviews, this doubting obsession developed as a desperately needed aid to the continued repression of what had seemed to the patient to be accumulated rage of a murderous level which had accordingly been totally unacceptable to conscious awareness. The obsessive thought has an element of projection here. She must conceal from herself her own negative feelings. In reverse fashion her time, energy and attention become occupied with obsessive doubts about her husband's love. The terrible parental incompatibilities present in her own childhood had resulted in her developing a docile and compliant nature in which there was no room for recognition of hostile and aggressive feelings. Inevitably the continued repression of everything negative created an increasing internal pressure which became ever more threatening to break loose. The doubting obsession even "reversed the threat" as a further effort at denial, obscurement and concealment.

This case also demonstrates the epigain, the secondary unconscious gain possible in obsessive processes which is sometimes less marked and more obscure than in other neuroses. The effect on husband is to stimulate even greater efforts to prove his love. He becomes even more solicitous in an effort to meet the unrealistically (and unconsciously) desired standard of an "ideal" father, which would then presumably merit a complete absence of negative feelings. The self-defeating effects of this "gain" become obvious. The more forced and required the responses become to her dependent demands, the more resentful and insincere the husband will be. The patient will actually lose love and will feel more guilty. There are of course many other dynamic implications present which may occur to the interested student.

On closer inspection, the obsessional patient's outward apparent independence, seeming thick skin, and emotional restriction may be largely a facade, developed because of his own internal weakness, vulnerability and doubts. Thus, an obsessional may have trouble saying "no," or refusing a request, or even sticking up for his own rights despite external appearance to the contrary. I believe Sullivan[17] must have been thinking somewhat along these lines when he commented that what the severe obsessionals often themselves regard as hatred "on more closer scrutiny, proves to be their shocking vulnerability to almost anybody. . . ." Further, according to him, obsessional substitutions are "attenuations of contact which protect them from their abnormal vulnerability to anxiety." The obsessional must remain relatively distant because of his own concealed but strong internal doubts, fears, low self-esteem, and "shocking vulnerability."

Repression, displacement and substitution are the important unconscious mental processes in obsessional neurosis. The displacement is to something seemingly remote but nevertheless closely associated with the incompletely repressed idea or desire. As Silverberg[18] has pointed out (and have others), obsessional defenses are "another device of the ego to maintain incomplete repression. . . ." The obsessive may use projection to a greater or lesser extent but it is not as important a mechanism as the foregoing. On the other hand, in view of his harsh superego and his low level of self-esteem, he not infrequently serves to illustrate the King David Reaction. This is an interesting psychologic process involving the employment of identification, projection and rationalization. Through it, repressed self-condemnation and self-disapproval become subjectively experienced as negative feelings toward another person. The first person unconsciously sees himself (his rejected traits) in the other person toward whom as a result he may experience intense dislike. Sometimes King David's Anger is stimulated by unrecognized physical resemblance.[19]

Earlier we considered a number of the defensive character traits developed by obsessive patients and some of the defensive purposes they were intended to serve. An important one was the need for perfectionism. A rather striking but extreme case* illustrative of this was reported to me while using this material recently in graduate medical teaching.

Case 9. A large jewelry firm regularly found a few perfect diamonds missing at periodic inventories and for a period of time these irregular and seemingly inconsistent losses remained unaccountable. Finally, however, it was traced to one of their most devoted and trusted diamond experts. He had developed such a tremendous need for perfection that he simply could not stand an imperfect stone. As a result, when a customer occasionally brought in a chipped gem for resetting, or an imperfect one, he simply replaced it with a perfect stone from the firm's stock and threw away the diamond brought in by the customer. Needless to say, his great interest in supplying the firm's customers with only flawless diamonds was most poorly appreciated!

Should space permit we might examine in turn the hidden dynamics of each major obsessional symptom. For example Bleuler[4] noted that "obsessional cleanliness may frequently be traced to the need for moral purity, . . ." and, in regard to the moralistic trends, Freud[5] stated, ". . . In order to protect object-love from the hostility which lurks behind it, the obsessional neurotic is compelled to build up an overconscientious system of ultramorality. . . ."

I have pointed out that obsessional symptoms develop also as a defense against recognition of sexual impulses. Brill[20] cited an interesting case of the development of the disturbing, but reversed and disguised, obsessional thought, "God might get into me," in a retiring and inhibited young man who had pointed out to him by fellow workers 2 dogs in coitus, and the (to him) terribly embarrassing question was asked, "How would you like to be the top dog?" The protestive and denying thought had first been, "No, you are not going to get into the dog," which by forgotten steps of psychologic processes had evolved into the disguised and apparently meaningless obsessional thought. For the interested student, there are considerable clinical data as well as more detailed discussions of dynamics in the literature which can implement the current discussion (e.g., Freud's early [1909] "Notes upon a Case of Obsessional Neurosis"[21]).

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* Reported to me by Dr. John A. Bowler, Jr.

The Impulsions

The impulsions include a group of reactions characterized by compulsions to commit unlawful or socially disapproved actions. Herein are included such acts as pyromania, kleptomania, and exhibitionism. These acts tend to be repetitive, pointing up their relation to compulsive rituals. The impulsion differs from the compulsion in that the person concerned acts upon his urges despite their antisocial nature. There are also major elements of hostility, aggression, and defiance "acted out" by the individual concerned. Part of his rebellion and hatred of authority is generalized rather to include society as a whole, which may be subjectively perceived by the individual as a threatening environment. Of course he inevitably winds up in self-defeating fashion by making it more so! With the impulsions there is often the hidden element of gratification, often symbolically, of consciously disowned impulses.*

Impulsions are more or less uncontrollable and are often repeated despite apprehension and punishment. Indeed, it is not unusual for the coëxistence of a need to seek punishment (and forgiveness) at the same time. As a result, the act may be committed in a manner that seemingly ensures detection. With certain patients it is as though punishment then provides a clean slate and he may then begin over again. Certain types of sexual activity and substitute gratification may be included in the impulsions. The patient may or may not experience some degree of reluctance before the act and remorse in highly variable degree afterward. Generally, the person has a full understanding of the potential consequences of what he does. In view of their antisocial consequences the impulsions have increased importance by virtue of complex and often controversial medico-legal implications.

Among the more common impulsions are:

DIPSOMANIA—compulsive drinking, with which periodic behavior disturbances are frequently associated

EXHIBITIONISM—compulsive physical exposure with perverse sexual gratification

KLEPTOMANIA—compulsive stealing

PYROMANIA—the compulsive starting of fires

VOYEURISM—sexually motivated compulsive spying on others.

The subjective experiences with the impulsions are somewhat comparable to the compulsions. Performance of the act is accompanied by a relief of tension. As White[22] stated, "These impulses appear without (apparent) cause, the patient is anxious or restless until they are carried out, and their accomplishment is accompanied by a feeling of relief." Impulsions are usually accompanied by a lack of logical realistic explanation for the act performed. There is often an element of concealed sexual meaning or stimulation and gratification. This is frequently present, for instance, in pyromania. Sometimes the offender will watch the results of his act, accompanying or following this by self-gratification.

Characteristic of kleptomania is that what is taken is not really needed or wanted in the ordinary sense. The kleptomaniac is often unable to really explain why he steals, or why he steals what he does. Furthermore, he is often well able to afford to purchase what he takes, as was true in the following instance:

Case 10. A wealthy woman was a typical kleptomaniac, apparently unable to control her shop-lifting impulses. On her intermittent trips to town she would pick up various odd assortments of merchandise. These items were ones for which she had no practical need and were usually of rather small value, and their total purchase price was insignificant to a person of her means.

The need to steal was clearly not financial, nor was there significant material gain. She was apprehended several times during her shop-lifting experiences and avoided prosecution by making prompt restitution or through use of her position. Other persons with kleptomania are less apt to receive such benign, nonpunitive and charitable treatment. In this instance there was no interest in, or motivation for treatment. This does not mean, however, that she was comfortable about her problem. Indeed she was tortured by conflicts and doubts. Even superficially there was evidence of great insecurity, social maladjustment, and unhappiness. Not the master of herself, she was driven by inner forces not accessible to her understanding or control.

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* Note the dynamic formulation here for later comparison with the displacement and externalization of the internal threats in the formation of a phobia which will be illustrated in the succeeding article on "Fear and Phobias." The original phobic object may also "generalize" to include associated objects or situations.

TREATMENT

Inscribed in the famous temple at Delphi of ancient Hellenic Greece were the words "Know Thyself." This admonition, which was respected for its wisdom in the ancient world, is equally applicable today. Learning to know oneself is the real endeavor of all sound psychotherapy. To the extent that this goal is successful on a truly deeper level is a real measure of the effectiveness of psychiatric treatment. Basic self-understanding would inevitably also help secure the understanding and acceptance of those emotions which arise, without resulting fear, anxiety and guilt, a major aim of modern therapy. In many cases, and particularly with cases of obsessive neurosis and obsessive character formation, analytic work seeks to free the long internally frozen, emotional assets. De-repression can take place permissibly and in a healthy direction. With adequate professional help the patient learns that his feelings are not uncontrollable, and that the negative and self-assertive elements are not "murderous" as he has feared.

We have seen how the obsessional is to those about him a good model citizen, a conformist, and a hard-working, persistent, virtuous and conscientious person. His suffering is rarely perceptible outwardly, consisting as it does in a marked crushing reduction of spontaneity with respect to both the warm and loving, and the self-assertive tendencies. On any level of conscious awareness his emotional life is restricted and dull. The obsessional fears manifestations of self-assertive spontaneity of any sort. To him they appear grossly disproportionate, magnified, uncontrollable and thereby potentially destructive of others (murderous). There is a frequently contributing background of a parent being anxious in response to the spontaneous expression of the child. This is quickly sensed and responded to in turn by the child, who becomes more frightened and uneasy about the destructive potentials of his feelings. It is not surprising that self-assertive tendencies are feared and totally rejected to deep levels of unconsciousness as "murderous," to be later mobilized and dealt with in more healthy fashion in those patients who successfully undertake therapy.

There is a vast and most important differential, however, between understanding on a strictly intellectual and academic level and that which includes the emotional. One is not concerned with added information alone, but with ability to function, effectiveness and satisfaction in living, with the ability to promote and maintain good relationships, and with the post-treatment status of the patient's emotional feelings. Emotional understanding or insight is vital to the important goal of helping these patients build up most needed self-esteem. In a recent stimulating address, Dr. Kenneth E. Appel[23] stressed the importance of emotional feelings in therapy and in what transpired between physician and patient. Dunbar[24] made comparable comments in discussing the actually long recognized importance of the physician's "bedside manner."

From a careful reading of the foregoing pages the reader may have some idea of the problems inherent to the treatment of the obsessive-defense reactions. Since these people were themselves more than likely treated with impatience and intolerance in early life, they are likely to have in turn a limited capacity to be tolerant or kindly toward themselves or toward others. These handicaps inevitably enter into the therapeutic situation. Poor tolerance may develop toward the therapist and his ideas. The patient may have so little positive desire to meet the imagined wishes (to coöperate in the work of treatment) of the therapist that he can quite conceivably and inadvertently defeat all efforts to help him. On the successful working out of the patient-therapist relationship may well hang the relative success or failure of the entire treatment. This relationship offers the patient the opportunity of observing at close hand, with the aid of the therapist as an expert, and to study how the ways in which he thinks, feels, and behaves often inadvertently influence profoundly the interpersonal situation. The observation and study of matters of transference and counter-transference are very important but must be reserved for more technical discussions elsewhere. For now it must suffice to point out that the analytic therapist comes to be regarded as a parental figure and earlier relationships and problems in them are recapitulated in the therapeutic situation.

Many of these patients can benefit a great deal from treatment. Their adjustment, effectiveness in living, and level of maturity can be substantially improved.

The treatment of choice is psychotherapy on as intensive a basis as is feasible and useful. Although certain character traits common to obsessionals (e.g., rigidity, stubbornness, and obstinacy) tend to prolong and handicap therapy, others (e.g., superior intelligence, persistence, conscientious endeavor, and diligence) can usually be enlisted as useful allies to treatment. One can expect, however, that a thorough psychoanalysis in instances of character defenses, or in cases of mild to moderate obsessional neuroses, may well require several years of intensive collaborative work. When the patient is limited in his coöperation and when the neurosis is severe and well-established, the period of treatment can become quite extended. Defensive patterns which are laid down as thoroughly as the obsessive ones and in response to such fierce internal psychologic needs are not readily surrendered. Further, there is the basic defense of these patients in their poor tolerance of change and their resistance to new ideas and attitudes. This fundamental attribute helps ensure the generally slow rate of progress to be expected.

One important goal of therapy not often enough stated is the adjustment of the self-estimation or self-picture. Discrepancies usually exist to some extent or other between the picture we have of ourselves and that which others have of us. This is, of course, often defensive, for example, (1) the result of the development of character defenses and reaction formations, and (2) the maintenance of non-awareness in order to prevent the recognition of traits which may be disapproved or condemned in oneself. These discrepancies may be very great. I recall a patient who regarded herself as a constant victim and who felt badly treated and continually pushed around. This helped conceal from her any recognition of what was actually very aggressive behavior, a domineering role in her relationships, and considerable contempt and scorn for most of her associates. In the paper, "King David's Anger," which appeared in the January, 1954 *Psychoanalytic Quarterly*,[19] I have cited several examples of the violent reaction which can occur when sudden awareness is inadvertently gained of the negative aspects of one's self-appraisal. As the result of successful psychotherapy, the self-picture and that held by others will more closely approximate. Increased self-respect is likewise a consequence.

The value of the possession of an accurate and objective picture of oneself has long been recognized. Robert Burns, in often quoted lines, stated this in 1786:

> "Oh wad some Power the giftie gie us
> To see oursels as Others see us!"

Today, while this paper is in preparation, a patient in his third year of fruitful therapy spontaneously told me, "The real value of analysis is that it shows me what I really am. Through some useful changes I've made and because I'm genuinely more tolerant, this then becomes acceptable to me. I'm more comfortable and more accepting of myself." Self-understanding is of universal value. By 1920 analysts were being urged to undertake a personal analysis,[25] a study that is today considered a prerequisite to a mastery of the technic of psychoanalysis as well as a valuable individual asset.

There are many special points which might be considered in the treatment of the obsessive patient. For example, where the disturbing obsessive ideas relate to injury to family members, it is always helpful for the therapist to discover if there have been fantasies about their absence. He can also determine what this situation might be like from a hypothetical position of its having actually transpired. Actually it is always useful to inquire when the ideas first appeared; as Freud[21] noted, this may result in their being placed farther and farther back in time. This is likely to be particularly true in long-term therapy when one will often be led to earlier and earlier data. With all obsessive ideas the physician may find it helpful to constantly keep in the foreground the question as to what painful idea or impulse requires the substitution and displacement which has occurred. One must be cautious of obsessive ideas which develop suddenly, as being possibly prodromal to a psychotic episode, should the newly acquired, desperately needed obsessional defense prove insufficient or break down.

Mention has been made of the specific problems encountered in the long-term psychotherapy or psychoanalysis which, as Fromm-Reichmann[26] has pointed out, is necessary for real insight therapy. Sharpe[27] noted the use by the patient of interpretations made and insights gained in typical obsessional fashion, and Sullivan[28] called attention to the security operations of these patients in therapy which result in anxious deletions and increase the difficulty of the psychiatrist's task. Fromm-Reichmann[26] notes that in the treatment relationship, "Obsessional patients . . . may make use of their repetitive, argumentative, manipulative, and compulsive ways of interpersonal behavior." She also later notes the value of the therapist's directing attention to major issues. As these are clarified, side ones can be skipped, actually perhaps avoiding an obsessional pattern of treatment. To be further noted, as earlier illustrated, the obsessional is driven to use words, careful phraseology, and the academic approach to "control" the treatment situation—actually to control anxiety and discomfort arising from inadvertent expression of emotions.

At this point we might appropriately consider the vast influence which can be exerted upon the entire future of an individual as well as upon the course of the illness by the response of the respected person from whom advice may be early sought. This has general application in varied forms in emotional illness. It was recently forcibly demonstrated to me in 2 cases of obsessional preoccupation similar to case 3. These afford us the opportunity to contrast the effects of an objective and neutral attitude of curious inquiry with one which is biased, or when perhaps the "expert" from whom help and counsel is sought suffers from similar conflicts.

Each case involved a young mother greatly concerned because of recurrent highly unacceptable thoughts of harming her small children. As a result of the deep level of concern present over such consciously abhorrent and disturbing thoughts, each sought religious counsel. Let us see what happened. In the first instance the minister sided with the patient's conscience and condemned the thoughts. To him, these were very sinful. He got down on his knees with the patient and prayed for the patient's forgiveness and urged increased will power and self control. In the second instance the religious counselor in kindly fashion indicated his understanding of how upset the patient must feel. However, he said that perhaps the moral implications of her thoughts were not as bad as she had feared. Finally he indicated that there must be some basis for the disturbing thoughts which were at present poorly understood and he advised that expert help be sought.

What were the results? In the first case the conflicts were increased as the minister sided with her already harsh and condemning conscience. The patient became more convinced than ever of her guilt and unworthiness. Consultation was long delayed and many months of suffering were added. With the second case, in sharp contrast, the initiation of adequate psychotherapy was facilitated and the burden of an already overburdening judgmental conscience was not increased.

Although applicable in all sound psychoanalytically oriented therapy, I should point out particularly here the danger of premature interpretations. Ideas should be presented to the patient sparingly and only after careful consideration. They must be sound, supported or supportable by factual data secured from the patient, and presented as briefly, clearly and concisely as possible. Any other course enhances the chances for rejection and stimulates resistance. Further, later interpretations will fare better if an early pattern of success is established in which the therapist's comments clearly make sense to the patient.

Unsupported speculation should be kept to oneself. If one has to debate between silence and speaking, choose the former. One can always return and pick up an earlier point. One cannot recall an inadvertent, clumsy, meaningless, misleading, or inane comment once made.

One must gear comments also to the level of possible reception and receptivity present. These patients cannot be pushed. Attempts to unduly hurry treatment will more than defeat their intent. Although they may reflect anxiety or impatience on the part of therapist, or of therapist in response to patient, "pushing the treatment" will only in turn stimulate more anxiety, with resulting increased resistance, the reverse effect from that desired, and ground will be lost rather than gained. This may be even more true with the sicker patient, i.e., the patient who needs to maintain more notable obsessive defenses. The reader can perhaps gain some appreciation of the need for patience, persistence and tenacity on the part of the therapist who can successfully work with obsessive patients.

Patients with obsessional tendencies are the most easily managed ones in general practice. The responsibility of the physician lies frequently in his own recognition of the presence of limiting obsessional character traits or symptoms, and taking the initiative in the early preparations for psychiatric consultation and treatment.

Although it may not be outwardly apparent, the obsessional is an unhappy sufferer who is driven and miserable, often without knowing it. His emotional potential for more fully creative and satisfying living is locked securely within. He (the ego or self) is in a very hard-pressed position in the obsessive process. His "triple defense" is simultaneously against his own harsh and constantly grinding conscience; secondly, against society because of his great vulnerability to people and resulting defensive need for distance; and thirdly, in efforts to control feared and rejected impulses. Thus, the ego is at the mercy of an overburdening conscience which is critical and condemning of what is felt or done. Driven by feelings of guilt and responsibility, there is desperate striving to maintain inhibition and control over all kinds of emotional feelings, so many of which must be rejected and deeply buried from conscious awareness within himself. Ordinarily neuroses are regarded as less severe than psychoses. Actually some neuroses are more disabling and disturbing. Occasionally this is illustrated by the severe obsessive who is literally a slave to his obsessions or compulsions.

When these efforts are successful in freezing the threatening and frightening emotions internally, the obsessive may reach an internal adjustment with which he is content, however limiting and restrictive this may be to his ability to live fully or to achieve a reasonable degree of satisfaction in life commensurate with his real capacity. Thus, when his internal defenses achieve their purpose (endogain) adequately, the obsessional will not seek nor want help. He is satisfied with his status quo, doomed to a life of restriction and handicap without even knowing it. What a sad, hopeless, and insoluble dilemma!

Usually it is only when awareness (de-repression) threatens of disowned impulses from his unconscious that anxiety arises which may motivate the obsessional toward treatment. Treatment when successful can unlock the long rusting doors to permit constructive release, examination, and healthy utilization of the patient's hidden emotional potentials, as well as lowering the level of anxiety and securing resolution of the conflicts which lead these patients into treatment.

Thus, for those who have the requisite patience and pertinacity, the results of long-term intensive psychotherapy are highly rewarding. These able and useful people are a distinct social asset, and the therapeutic investment of time and effort is most sound. Perhaps I might close these brief notes on therapy with a meaningful brief quotation of an obsessive who was well along in his analysis about the basis for his unrealistically high standards: "When I think of my life during the past 20 years or more it has been a constant effort and struggle to be something beyond myself. My aims and goals have been in truth illusory. What a vast amount of desperate striving toward an unobtainable goal! Now that I've been able to see this, at least in part thus far, it seems less necessary, but also in the past rather tragic and futile." This patient's endless struggle was initiated by the endeavor to gain complete parental acceptance, approval, and love. Parents were actually long dead, but their impossibly difficult standards were internalized as part of the patient's own super ego. The patient's struggle for a now at least mythical goal was indeed hopeless, illusory, and tragic.

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President's Page

GOVERNMENT BY COMMITTEE

As of May 31, 1954, the Medical Society's membership rolls comprised about 1950 physicians in the following categories: Active, 1369; Life, 77; Associate, 444; Honorary, 20; Affiliate, 17; Resident-Intern, 19. Of these the Active and Life members, totaling 1446, constitute the voting membership of the Society. The total membership of all classes in 1940 was 1096.

In recent years it has been impossible to determine with any satisfaction the composite opinion of Medical Society members. The hall will accommodate 485 out of 1946 members, and business meetings as a rule are attended by less than 10% of the membership, even after repeated notices and reminders. The best mail poll vote ever taken of the membership received responses from about 55 to 60% of the members.

This Medical Society is one of the most active of the state medical societies. It has 33 active committees. The day-to-day necessity for immediate decisions on many points makes it quite apparent that the old system of voting on all points in a called Society meeting has gradually changed to a Society of operation by committee. The committees in turn are bound by previous general policy actions of the whole Society. The committees mentioned are composed of about 250 members of the Society.

The Society will of necessity have to depend more and more upon officers, the Executive Board and the various committees, and less upon Society debate--unless it be willing to set up a house of delegates, as in many other state medical societies.

Herbert P. Ramsey

Editorials

DISTRIBUTION OF POLIOMYELITIS IMMUNE GLOBULIN FOR 1954 IN WASHINGTON

The results of the protection against paralyzing poliomyelitis in major epidemics with the use of the human blood fraction, gamma globulin, were not considered to be of much or any value during the calendar year 1953. The results were reached during statistical studies after its distribution last year. It is, however, concluded that to evaluate this material is extremely difficult because of the nature of the disease itself. It is known, too, that gamma globulin contains antibodies against all three types of the disease and, if any prophylaxis or attenuation of the disease is produced, it is for a short duration of a few weeks. Since, if it is of value, it is of a passive nature, after several weeks it loses its effectiveness.

It will be recalled, last year in the District of Columbia the plan was to make this available for household contacts up to 30 years of age and pregnant women of any age. There is insufficient evidence of its effectiveness in controlling the occurrence or the severity of the disease, and its value in community prophylaxis has not been adequately demonstrated, according to the conclusions reached at a conference in New York City, March 5 and 6, 1954, which was made up of representatives of the State and Territorial Health Officers Association, the Office of Defense Mobilization, the National Foundation for Infantile Paralysis, and the American Red Cross.

This year, based on the epidemiological statistical reports of 1953, the Office of Defense Mobilization has transmitted to the United States Public Health Service the following distribution plan:

1. Forty-five per cent of the supply of gamma globulin available for the prophylaxis of poliomyelitis will be set aside for the states, territories and the District of Columbia in accordance with each jurisdiction's proportionate share of the national aggregate number of reported poliomyelitis cases during the five-year period, 1949 to 1953. Issuances will be made upon request by the official health officer.

2. Forty-five per cent of the supply of gamma globulin available for the prophylaxis of poliomyelitis will be set aside in accordance with each jurisdiction's proportionate share of the total population (1950) under age 15 in counties which had annual crude poliomyelitis attack rates (based on 20 or more cases per 100,000) at least 4 times the national poliomyelitis crude attack rate during any of the years, 1949 to 1953. Adjustments will be made for those areas participating in the vaccine field trial.

3. Ten per cent of the supply of gamma globulin available for the prophylaxis of poliomyelitis will be held as a contingency reserve for issuance to the official health officers on special request.

The Executive Committee of the Association of State and Territorial Health Officers and the Office of Defense Mobilization have reached agreement with the National Foundation for Infantile Paralysis, Inc. and the American National Red Cross that these latter organizations

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia.

will provide poliomyelitis immune globulin to be distributed according to the following criteria which, unless they are modified or changed, will be in effect during the poliomyelitis season of 1954.

1. That poliomyelitis immune globulin be used only in group inoculations in groups larger than a single family unit, such as a neighborhood, an apartment house, a housing project, a school or institution, a camp, an area or district within a community, or a community as a whole.

2. That each state, territorial or District of Columbia health officer shall determine, in the light of existing circumstances, those people who for this purpose constitute a group, making certain the group is larger than a single family or single household; shall determine the time when the group inoculation is to be given, the area in which it will be used, and the size of the dose to be given each individual. (In 1953 the average dose was 7 c.c.; it is recommended that this be increased to 10 c.c. in 1954. Last year the recommended dosage was 0.14 c.c. per body pound of weight with the maximum issued for any one individual not to exceed 20 c.c. In light of the above recommendation, it is suggested that the dosage be increased proportionately or at least 0.2 c.c. per pound of body weight.)

3. That poliomyelitis immune globulin shall be used in areas selected by the state or territorial health officer and the National Foundation for Infantile Paralysis for a trial of the vaccine developed by Dr. Jonas Salk for the National Foundation for Infantile Paralysis, only where in the opinion of the state or territorial health officer it will not affect the validity of the vaccine field trial. This does not affect the use of gamma globulin for the control of measles and infectious hepatitis and in unusual circumstances.

Further information regarding the distribution of this product can be obtained by calling the Office of Preventable Diseases of the District of Columbia Department of Public Health, at National 8-6000, extensions 2128, 2129 or 2134.

John R. Pate, M.D., M.P.H.
Director, Bureau of Disease Control,
D. C. Department of Public Health

PANEL DISCUSSIONS FOR THE PUBLIC

A recent newspaper item notes that a panel discussion on medical subjects with public participation will be inaugurated in this vicinity in the near future.

Some of the elder members of our Society will recall some twenty years ago a similar program, initiated by the Medical Society of the District of Columbia, was held every Sunday afternoon in our auditorium, and it apparently filled a want. It was discontinued for no single tangible reason, but possibly for a combination of reasons. One outstanding meeting had an overflow crowd and on that occasion the late William A. White held the audience almost spellbound by a psychiatric discussion.

Possibly the trend of the times, which has occupied our thoughts mostly with military, economic, and political questions, has replaced to some extent our interest in things medical, but it would seem that the time is always right for the illumination of health problems.

A program for public discussion requires more than passing thought, because there are many and devious angles which should be avoided since they have no place in such a convention. Those responsible for settng up such a program should have the guidance of a journalist or some one equally conversant with the art and practice of publicity. The topics should be carefully selected and their limitations stressed. Although it is true that controversial subjects generally attract the larger audiences, and few persons are attracted by the mere recitation of factual data, yet it is possible to present a program of general public interest without delving into personalities. In the unfathomed fields of medicine it is fundamental that truth must not be sacrificed to the spectacular.

We are only too familiar with many current extravagant and misleading statements relative to progress in our field that appear in the press and magazines. Such contributions do not enhance the public's confidence in the members of our profession but often raise false hopes among the ill and despondent.

The panel discussion is a fertile field for us and we should embrace the opportunity to engage in this activity. A committee selected for its grasp of public interest and sentiment, with the assistance of mature and unbiased persons in public life, could render a great service in any community. The medical profession suffers from insufficient and often unfair publicity, due possibly to our reticence to assert ourselves by the means of communication at our disposal. Should we try it again?

C. S. W.

SOUTHERN PEDIATRIC SEMINAR

There was a reminder in the mail the other day from Dr. Julian P. Price, Florence, South Carolina, that the 34th Annual Session of the Southern Pediatric Seminar will be held, July 12 through July 31, 1954.

The Seminar is described as a course "in Internal Medicine, Obstetrics and Gynecology, and Pediatrics: the newest methods of diagnosis, prevention, and treatment. In all these fields, the lecturers stress the solution of ordinary daily problems in the most modern, scientific and satisfactory way. The course being designed to fit the needs of the general practitioner, the criterion is not theory but practice."

The faculty is headed by Dr. Price, who is Dean; Dr. Lee Bivings, of Emory University, is Vice Dean; Dr. D. Lesesne Smith, Jr., Spartanburg, S.C., Registrar; Dr. James Donnelly, Bowman Gray School of Medicine, Dean of Obstetrics; and Dr. Hugh H. Hussey, Professor and Head of the Department of Preventive Medicine and Public Health, Georgetown University School of Medicine, Dean of Internal Medicine.

Aside from Dr. Hussey, others appearing on the 3-week program from Washington are Dr. W. Proctor Harvey, Assistant Professor of Medicine, Georgetown University School of Medicine, Dr. Preston A. McLendon, Professor of Pediatrics, George Washington University School of Medicine, and Dr. Marcus Schaaf, Chief Medical Officer in Medicine, District of Columbia General Hospital.

The brochure states that the faculty is " a happily balanced combination of professors and practitioners who volunteer their services to create a unique teaching center where the most advanced information—not medical rarities—is presented."

The reader is also informed that the Seminar is nonprofit and is not subsidized. Furthermore, that the faculty and guest lecturers serve not only without compensation but at their own expense.

The Seminar will be held at Saluda, North Carolina, in the heart of the Blue Ridge Mountains. Because of its location it should attract many physicians who wish to combine business with pleasure. Entertainment is planned for wives of physicians, including extensive tours to spots of interest in the vicinity.

The regristration fee for the course is $25.00 per week. Registration for one week is acceptable. Advance registration is requested because, as it is explained, classes are limited to 125. Credit for attendance is given by the American Academy of General Practice.

Applications for participation should be directed to Mr. M. A. Owings, Secretary-Treasurer, Saluda, North Carolina.

T. W.

A NICKEL AND A PAUSE

The most unique innovation in the Medical Society's building during President Ramsey's administration will never be described in the Society's official reports. But by the office staff his presidential year will be most gratefully remembered by the installation of the Coke dispenser.

The need for a thirst quencher had been recognized for a long time, but to place such a huge red package in the quiet vestibule of the Society's home seemed an affront somehow to the building's architectural dignity.

However, as time marched on, the meetings of the Executive Board grew longer, and the throats of Executive Board members drier, until President Ramsey deemed the time had come to take measures worthy of the organization he heads. But where to place "the blooming thing" so that its flaming color would not be offensive to any members with political sensitivities?

The women's cloakroom in the Medical Society has always been noteworthy for its expansive qualities. Time was when it was just a cloakroom, like its counterpart for the men across the hall. For several years an immense work table filled all but the corners and it doubled as a mailing room. When a spot was needed for the embryo MEDICAL BUREAU, where was room found for it? Why, the women's cloakroom somehow expanded enough to accommodate it and held it until the infant had grown so lusty that space had to be made for it elsewhere.

With the BUREAU gone, the cloakroom reverted to its original size and purpose. Therefore, when a place was needed for the new dispenser and for the somewhat unsightly box or two of empty bottles which would hover in its shadow, the women's cloakroom was obviously the ideal spot. The gentlemen all agreed, and not a lady voiced a protest (ladies get thirsty too).

Members of the Society who have not availed themselves of this singular advance in paramedical progress are urged to do so lest the machine suffer from lack of business and be removed. This was the fate of the cigarette vender, which languished briefly also in the women's cloakroom. From a practical standpoint this was just as well, because the cigarette vender usurped the space allotted to the supply cabinet, and the displaced supply cabinet in its central position became such an obstacle that the female contingent of the office staff had to execute a sort of letter S in getting to their coat lockers.

If thirsty members will bear to the left as they enter the building, or to the right as they leave, they may, with a nickel and a pause, have a Coke that refreshes.

A. L. E.

PROCEEDINGS OF THE ANNUAL BUSINESS MEETING

Dr. Herbert P. Ramsey, President of the Medical Society of the District of Columbia, presided at the Society's Annual Business Meeting, May 5. Previous to the meeting, the "Annual Reports of Officers, the Executive Board and the Board of Censors for 1953–1954" had been sent to the membership. The Society voted to accept the reports without reading with the exception of one item regarding membership, which is referred to later in the summary of proceedings.

The Supplementary Report of the Executive Board, which is published in this issue following the Proceedings, was read by the Chairman of the Board, Dr. Walter Freeman, and was approved by the Society, following which a motion was made and approved regarding the administration of Hospital Service Agency (see footnote appended to Report).

PRESIDENT'S MESSAGE

Dr. Ramsey recalled to members present that 20 years ago that night he had accepted his first assignment with the Medical Society as Chairman of the Committee on Public Information; that the

Society had grown from a small group of 200 to almost 2,000 members. Because of its size, the Society must increasingly function through committee and Executive Board government.

Dr. Ramsey pointed out that the number of complaints received by the Grievance Committee is on the increase and that most of these had to do with fees. He reminded the membership that the Executive Board, in the administration of the Society, would back the Grievance Committee in its recommendations.

He called attention to one problem which so far has evaded solution, the matter of the large number of health and medical charities, concerning which every president was requested to address appeals to the members of the Society for funds.

His last point related to the position of leadership which he thought the Society should occupy, both in the local and in the national community. Complimenting the Secretary and the entire staff of the office, the ANNALS, and MEDICAL BUREAU for faithfulness and dedication to duty, he said there was a limit to what any given number of people could accomplish. The Society must pay the price of leadership and this could only be done by increasing the staff, enlarging the working quarters, and increasing its ability to send emissaries to conferences in the field of health, both local and national. He recommended that the Executive Board present to the Society for the year 1955 a new budget which would show increased appropriations for such expenditures together with a new schedule of dues sufficient to support the enlarged budget.

ANNUAL REPORT OF THE CHAIRMAN OF THE EXECUTIVE BOARD

Chairman Freeman presented a very brief summary of the principal activities and actions of the Executive Board. Much of the Board's time is devoted to routine matters, mention of which he avoided in his report. The Board meets regularly on the fourth Monday of each month.

Among the more important actions taken by the Board were: instructed Society's delegates to introduce in the meeting of the House of Delegates in June 1953 a resolution having to do with mental illness among Government employees as related to security; appropriated funds for remodeling MEDICAL BUREAU quarters at 1710 M Street; proposed to Director of Public Health, District of Columbia, that use of Civil Defense "Family Identification Tag" be considered for identifying persons having certain health conditions so that they would not be confused with narcotic addicts or alcoholics; created the John Benjamin Nichols Award to be presented to a lay person or organization or both for their contributions to the health of the community; notified Commissioner Spencer that the Board favored foreign physicians being required to take out first citizenship papers before being licensed; approved new regulations governing maternity and newborn care in hospitals of the District of Columbia; extended an invitation to the American Academy of General Practice to hold its 1956 meeting in Washington and to the AMA to hold its 1957 Clinical Session in Washington; approved a health poster contest as a joint project with the Woman's Auxiliary; at the request of Medical Service of the District of Columbia, polled voluntary hospitals of the District to ascertain what staff privileges were granted podiatrists; authorized the Editorial Board of the MEDICAL ANNALS to sponsor a House Officers' Essay Contest; and instructed the delegates to the AMA to introduce a resolution in the next meeting of the House in support of the proposed new building for the Armed Forces Medical Library.

Dr. Freeman presented to the Society for permanent membership 75 Active, 33 Associate, 2 Affiliate, and 3 Resident-Intern members who had been elected for a probationary period of one year. Included in the list for Associate membership were two podiatrists, whose confirmation by the Society was objected to by several members present. After some discussion pro and con, they were not confirmed.

The Chairman reported with regret the passing of 16 members of the Society during the past year. They were: Drs. Rush W. Conklin, Louis A. Cornet, Wesley C. Cox, William Gadol, Alexander Y. P. Garnett, Frank E. Gibson, Jospeh J. Kaveney, J. Thomas Kelley, Jr., Ralph M. LeComte, James G. McKay, David L. Maxwell, John B. Nichols, J. Edward Payne, Walter A. Rath, Thomas J. Rossiter, and S. Charles Woldenberg.

In concluding his report, Chairman Freeman expressed the hope that more members would familiarize themselves with their organization, which, in his opinion, is "one of the most effective medical societies in the country."

REPORT OF THE SECRETARY

The Secretary called attention to the extent of the Medical Society's activities, which reached a point in the past year where maximum effort is required of a comparatively modest staff. Indications are, he said, that if the demands continue to increase, additional expenditures for personnel will be essential.

STATE OF THE SOCIETY

Membership is at an all-time high. The steady growth of the Society in the past 10 years is reflected in the following figures as of May 1 of each of the years shown:

	1944	*1949*	*1954*
Active	925	1,267	1,359
Life	61	85	77
Associate	203	392	441
Honorary	9	16	20
Affiliate			17
Resident-Intern			18
TOTAL	1,198	1,660	1,932

The membership luncheons were not resumed until January, 1954. As of April 1, three luncheons had been held with a total attendance of 65. The primary purpose of the luncheons is to enlighten members as to the Society's history, activities, and finances, and to create a closer relationship between members and the Society's officers.

The financial report was presented at the March business meeting of the Society and copies of the report are available at the Society's Executive Offices to any member who may be interested in seeing them.

ACTIVITIES OF THE SOCIETY

The scientific program, limited during the previous year to the ANNUAL SCIENTIFIC ASSEMBLY and the MIDWINTER SEMINAR, was augmented during the past year by monthly meetings. These were initiated upon the suggestion of President Ramsey, who was anxious that a greater number of physicians make use of the Society's building so that it will continue to be the center of medical activity in Washington.

Attendance at the 24th ANNUAL SCIENTIFIC ASSEMBLY was most satisfactory, principally because the registration of physicians increased by more than 100 over the previous meeting. Of the total registration of 3,252, 1,815 were physicians, 356 were medical students, 222 nurses, and 121 medical and X-ray technicians. A new and popular feature of this year's ASSEMBLY was the dinner and entertainment given by the doctors for their office staffs. Both the Secretary and Assistant Secretary coöperated closely with the ASSEMBLY'S General Chairman, Dr. Jonathan M. Williams, and his committees.

From the standpoint of attendance, the THIRD MIDWINTER SEMINAR was also a resounding success. On the first evening the auditorium was filled to near capacity, approximately 460, and on the second and third nights, 350 and 325, respectively.

Dr. Hugh H. Hussey was Chairman of this year's Program Committee. Most of the credit for the success of the SEMINAR must go to Dr. Thomas M. Peery, who planned the program and obtained the speakers. The SEMINAR is now firmly established as a permanent feature of the Society's program.

The monthly meetings planned by the Program Committee were unique, both as to subject matter and the fact that the wives of the doctors were invited to attend. The first was held at the new Clinical Center of the National Institutes of Health in Bethesda, the others in the auditorium of the Society's building.

There has been no change in the Editorial Board of the MEDICAL ANNALS. The staff consists of: Dr. Wallace M. Yater, Editor; Theodore Wiprud, Managing Editor; A. Louise Eckburg, Assistant Editor; Drs. Frederic G. Burke, Frank D. Costenbader, Hugh H. Hussey, Winfred Overholser, Thomas M. Peery, Herbert P. Ramsey, R. Lee Spire, Donald Stubbs, and Charles Stanley White, members of the Editorial Board.

There was a small increase in circulation figures over 1952, and a small decrease in advertising revenue over the same period.

The past year saw expansion of MEDICAL BUREAU personnel, quarters and equipment. On October 9, 1953, at 6 a.m., 7 new, especially constructed switchboards were placed in operation. Expansion of the BUREAU'S facilities required the employment of 6 additional operators. Twenty-six full- and part-time operators are now employed. Remodeling the BUREAU'S quarters, the purchase and relocation of equipment, and other items cost $7,082.65. Subscribers' rates were, of necessity, increased, effective October 15, 1953, from $8 to $10 per month for Secretarial Service and from $4 to $6 per month for Alternate Listing Service.

On March 1, 1954, the BUREAU had 732 physician-subscribers, including 385 to Alternate Listing Service and 347 to Telephone Secretarial Service. On March 1, 1953, there were 733 physician-subscribers. At the present time the following organizations and institutions are connected to the BUREAU by "private wires": Children's, Doctors, Emergency, Garfield, Providence, Sibley, George Washington and Columbia Hospitals, the latter two having installed wires in March, 1954; also the Central Ambulance Service, Group Hospitalization, Inc., and Hospital Service Agency.

There was a substantial increase in the number of subscribers to MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA, which has enjoyed phenomenal growth in the six years of its existence. At the close of 1953, there were 404,034 persons covered by the Plan in the Washington Metropolitan Area. The number of Participating and Coöperating Physicians by the end of 1953 was 1,640.

Income from subscribers' dues, before operating expenses, during the first year of operation was $416,619.80; this figure had increased in 1953 to $4,606,220.44. Operating expenses, which were 14.5 per cent of the subscription income in 1948, were reduced to 8.9 per cent in 1953.

The Society's Secretary has been Secretary of MEDICAL SERVICE since it was organized. He has been most favorably impressed by the loyalty and interest of its policy-making body and by the efficiency of its administrative staff.

As of March 1, 1954, 3,541 physicians and their dependents were covered by GROUP HOSPITALIZATION, INC., as compared with 2,352 physicians and their dependents on March 1, 1953. This increase is due, in a large measure, to the election of a considerable number of new members, most of them in the younger age group.

The Society's Health and Accident Group Plan, underwritten by Mutual of Omaha, was introduced to Active members of the Society on September 18, 1952. The plan, developed and recommended by the Committee on Group Insurance, after a year of study of existing plans, provides liberal benefits at low cost to members of the Society. Since the opening date in 1952, 948 members have enrolled and are now participating in the group. Members desiring information on the plan should contact Mr. Joseph E. Jones, Administrator, Group Disability Plan, Mutual of Omaha, Ring Building, telephone Republic 7-8600.

A Symposium on "Look Again, Doctor!" for doctors and their wives was presented this year in place of the Symposium, "Patients Are People," which was held last year for doctors' office staffs and proved particularly successful. The speakers for this year's symposium were likewise members of the Medical Society, and the program was highly successful, both from the standpoint of attendance and audience response.

The Secretary was moderator for "The Question Hour," which had its "trial run" last year; it was repeated again at the District of Columbia General Hospital, April 8. Subjects covered were common legal problems, practical medical economics, medical licensure, organized medicine, and conducting a medical practice.

ACTIVITIES OF THE SECRETARY

The positions held by the Secretary in various civic, professional, and governmental organizations have been set forth repeatedly in the annual reports. Mention will be made here of only three new assignments: Secretary-Treasurer of the Conference of Presidents and Other Officers of State Medical Associations; member of the Medical Advisory Committee to the Board on Mental Health in the District of Columbia; and Lecturer on Medical Economics at Georgetown University School of Medicine.

In addition to the lectures at Georgetown University, the Secretary addressed the junior and senior medical students of the University of Arkansas and the Pulaski County Medical Society, both at Little Rock, Arkansas, January 4, 1954. With the students he discussed "Medical Practice—Today and Tomorrow," and to the doctors he spoke on the subject, "Who Pays the Doctor?"

In closing his report, the Secretary expressed his appreciation for the encouragement and coöperation of officers and members of the Society, and thanked the loyal staff at the Society's Executive Offices for their interest and efficiency.

ELECTION OF OFFICERS

The nominees for office, which had been presented by the Nominating Committee to the Society at its business meeting, March 3, were presented to the Society by the President, and were unanimously elected to office. They are:

President-elect: William Ross Morris
First Vice President: Paul R. Wilner
Second Vice President: Margaret M. Nicholson
Members of Executive Board: Herbert P. Ramsey, R. Lomax Wells, Karl C. Corley
Member of Board of Censors: James W. Watts
Delegate to American Medical Association: Raymond T. Holden
Alternate Delegate to AMA: Herbert S. Gates

Dr. Preston A. McLendon, who has served as President-elect during the past year, will take office as President of the Society on July 1, 1954; Dr. Morris, on July 1, 1955. With the exception of the delegates to the AMA, all officers of the Society begin their terms of office on July 1. Dr. Ramsey will serve for four years on the Executive Board; Dr. Wells will fill the unexpired term (one year) of Dr. William R. Ballinger, who has resigned; Dr. Corley will serve for two years, succeeding President-elect Morris. Dr. Watts' term on the Board of Censors will continue for three years. The delegates, Drs. Holden and Gates, are elected for a two-year period, beginning January 1, 1955.

Following the election of officers, Dr. Morris was escorted to the platform by Dr. McLendon. Both Dr. Morris and Dr. McLendon spoke briefly, Dr. Morris expressing his appreciation for the honor conferred upon him; Dr. McLendon spoke appreciatively of the work of Dr. Ramsey and called upon the membership to support and assist him in fulfilling his duties when he takes office as President on July 1.

Report of the Board of Censors

In presenting his report, the Chairman of the Board of Censors referred to the Board as the screening body of the organization where applications for membership are concerned. Following the reading of the names of applicants at a business meeting of the Society, the applications are referred to the Board of Censors. Sometime during the following two months applicants are interviewed and the Board determines whether or not the individuals applying are qualified for membership.

Since May 1, 1953, the Board has interviewed 84 applicants for membership. Most of them were recommended for election to membership; a few were held for further investigation.

In determining the applicant's qualifications for membership, the Secretary of the Board routinely writes previous medical societies to which the applicant belonged to ascertain his professional standing and membership status. If he has served with the Armed Forces he is required to provide the Board with photostats of documents showing that he he has served honorably. By this and other means the Board assures the Society that only the highest type physicians are elected to membership.

Forum on Problems to Be Discussed at AMA Meeting

Following the business session, the Society's delegates to the AMA, Dr. Hugh H. Hussey and Dr. Raymond T. Holden, presented to the membership some of the problems which would confront the House of Delegates at the forthcoming session in San Francisco, and called for some expression from the floor to indicate to them the wishes of the society.

Dr. Holden called attention to various aspects of the Administration's health program, such as amendments to the Public Health Service, Hill-Burton, and the Vocational Rehabilitation acts, and the proposal to reinsure voluntary health insurance plans, whether nonprofit or commercial. Dr. Holden also outlined some of the problems of veterans care legislation, particularly regarding service- and non-service connected disabilities, and civil versus military care for dependents of veterans.

Dr. Hussey asked for an expression of opinion regarding extension of Social Security benefits to self-employed persons, which the AMA has opposed, versus tax exemption for funds an individual might set aside for retirement purposes.

Three questions which would come before the next meeting of the House of Delegates in regard to osteopathy were discussed by Dr. Hussey. They are:

1. Should modern osteopathy be classified as cultist healing?

2. Should physicians be permitted to teach in osteopathic schools?

3. Is this whole matter for determination at national or state level?

A number of the members of the Society expressed their views on these controversial questions, but the attendance at the meeting was not large enough to consider any opinion more than an individual one.

SUPPLEMENTARY REPORT OF THE EXECUTIVE BOARD

This supplementary report includes matters dealt with by the Executive Board subsequent to the completion of the annual reports. Only such items as require action by the Society itself are incorporated.

Visiting Nurses Association. The Board's attention was called to the two-year-long discussions between representatives of the Visiting Nurses Association and the Health Department of the District of Columbia regarding contracts, and that the solution of the contract problem had been effected finally by the Board of Commissioners.

More recently a long study of relationships between the official and voluntary nursing groups, conducted by a special committee of United Community Services, had been repudiated by the Health Department. Offers on the part of representatives of UCS to meet with the Director of Health had met with little success.

Hospital Service Agency. Those of our members who have practiced in Washington for two decades or more know something about the history of Hospital Service Agency; that the agency was originally two organizations, the Central Admitting Bureau for Hospitals and the Medical-Dental Exchange.

The Central Admitting Bureau was established originally with funds contributed by District of Columbia organizations, including the Medical Society. Its function was to determine the eligibility of patients for free hospital and clinic care. Prior to its establishment the situation had been highly unsatisfactory because there was little effort to ascertain the eligibility of those who received free medical services.

The function of the Medical-Dental Exchange was to budget medical and dental bills. It had been in operation only a short time when it was evident that the need for its services was not as great as had been anticipated. In 1938 the Central Admitting Bureau and the Medical-Dental Exchange were merged and thereafter became the Health Security Administration. Under this name it grew rapidly and became a widely used clearing house for patients seeking free hospital and medical care.

Among the functions of HSA was the distribution of Community Chest funds not only in the District but in the nearby counties of Arlington, Fairfax, Montgomery and Prince Georges as well as the city of Alexandria (later Arlington and Montgomery Counties set up their own plans for distributing Chest funds). It was determined in many cases that patients could be shown how to budget their own funds to handle both hospital and doctors' bills, thus assuming responsibility for their obligations without community aid. This in effect stretched the usefulness of the Community Chest funds. In other cases where patients were able to pay part of the cost of hospital care, but not the cost of medical care, they were encouraged to pay that part, and thus again stretch the use of the community dollar.

In 1948 the Health Security Administration became Hospital Service Agency and as such continued to perform the services for which it was originally established in 1935. Since that time HSA has been the subject of several studies by United Community Services. The so-called Fisher Howe Committee recently submitted tentative recommendations which would make HSA a UCS agency and place it under the direction of the Hospital Council of the National Capital Area.

It has been the Executive Board's position that doctors have a legitimate interest in the continuance of HSA. If it is operated efficiently they are assured that those who receive services without charge are entitled to them. In this crucial period of HSA's history the Board has supported the Board of Trustees of HSA in its efforts to maintain the Agency's independence.

The purpose of bringing this matter to the attention of the Society at this time is to request its endorsement of the following recommendations:

That the Society affirm its confidence in the accomplishments of Hospital Service Agency of the Washington Area and express its belief in the following principles:

a. That hospitals should be paid at the cost rate for the hospital care of indigent or semi-indigent patients whether from tax funds or contributed funds.*

b. That Hospital Service Agency should be maintained as an independent metropolitan area agency to balance the interests of hospitals, Community Chests, physicians and the public respecting patients supported by contributed funds.

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* Subsequent to the adoption of the Executive Board's Report as a whole, upon motion of Dr. Ernest Gould, the Society voted to inform the Hospital Service Agency, if reports that patients are being diverted from hospitals of their choice are true, the Society disapproves.

Chronic Disease Hospital. It has long been evident that the health facilities most required in the Washington Metropolitan Area are beds for patients suffering from chronic illness. Some figures recently obtained are illustrative of the situation which exists. Mental and general hospital beds in existence and under construction equal or exceed requirements; tuberculosis beds equal 66⅔ per cent of the community needs; health centers provide 28.1 per cent of the need, while chronic disease beds exist to only 11.1 per cent of the requirements. There are at present 182 beds in the Washington Home for Incurables out of a necessary minimum of 1,624.

This is a particularly propitious time to obtain Federal assistance for a chronic disease hospital. Under the Hill-Burton Act the Government will contribute two thirds of the cost to the District of Columbia only in the case of a chronic disease hospital. It will contribute 50 per cent for this purpose under Public Law 221, 82nd Congress.

As stated by Dr. Herbert P. Ramsey, President of the Society, in his President's Message in the May MEDICAL ANNALS, "A campaign raising two million dollars for such an institution would get four to four and a half million dollars total under these two laws. Where is there to be found a group of public-spirited citizens who will undertake to spearhead such a movement to build and operate a chronic disease hospital of 350 to 400 beds?"

Dr. Joel T. Boone Proposed for Honorary Membership. At its meeting on March 22, 1954 the Executive Board voted to propose Dr. Joel T. Boone, Chief Medical Director of the Veterans Administration, succeeding Dr. Paul B. Magnuson, for Honorary membership. Dr. Boone is well known to members of the Society and it is hardly necessary to elaborate upon his distinguished career as a physician.

In the First World War he was battalion and regimental surgeon for the Sixth Marine Regiment, later being made Assistant Division Surgeon of the Second Army Division, A.E.F. For extraordinary heroism he was awarded the Medal of Honor by Congress.

Among his subsequent assignments were Director of Naval Affairs for the American Red Cross, Physician to Presidents Harding and Coolidge, and Personal Physician to President Hoover. In World War II he was Fleet Medical Officer on the staff of Admiral W. F. Halsey. Dr. Boone retired as a Vice Admiral on December 1, 1950 after spending 36 years in the Navy.

In 1946–47, while on loan from the Navy, Dr. Boone served as Medical Advisor to the Federal Coal Mine Administrator and as Director of Medical Survey of the Coal Industry. The important "Medical Survey of Bituminous Coal Industry" was published as a result of his studies at that time.

In compliance with the requirements of the Society's Constitution and By-laws, Dr. Boone's membership is proposed at this meeting and will be voted upon at a subsequent one, possibly in the fall of this year.

Election of Dr. Frank B. Berry to Honorary Membership. Dr. Berry was proposed for Honorary membership at the March Business Meeting of the Society. At that time the Society was informed that Dr. Berry had recently been appointed Assistant Secretary of Defense (Health and Medical) to succeed Dr. Melvin A. Casberg, who is also an Honorary member.

A graduate of the Harvard Medical School (1917), Dr. Barry is Professor of Clinical Surgery at the College of Physicians and Surgeons, Columbia University. He is now on indefinite leave of absence.

Dr. Berry also distinguished himself in both World Wars I and II, rising to the rank of Brigadier General in the Army Reserves.

With the approval of the Board of Censors the Executive Board is pleased to recommend Dr. Berry's election to Honorary membership.

Election of Dr. You Chan Yang to Honorary Membership. Dr. You Chan Yang is the Ambassador to the United States from the Republic of Korea. He was graduated from the University of Hawaii in 1917 and entered Boston University's College of Liberal Arts on a scholarship. He received his B.S. degree in 1920, and his M.D. degree from the Boston University Medical School in 1922.

Dr. Yang began private practice in Honolulu in 1923 and was appointed Ambassador to the United States in 1951.

With the approval of the Board of Censors, your Board is pleased to recommend Dr. Yang's election.

Proposed Commission to Arbitrate Malpractice Claims. The malpractice situation in the District of Columbia has long been a source of deep concern to members of the Society. Various means of combating the rapid increase in claims have been suggested. One has been the so-called pre-trial commission or adjudication board. A year or so ago such a commission was proposed but was indifferently received. Recently, however, the Society's Committee on Coöperation with the Bar Association has held meetings with representatives of the D. C. Bar Association and concluded that such a commission could make a genuine contribution to the welfare of both the professions and the public.

At its last meeting on April 26 the Executive Board received a report from its Committee on Coöperation with the Bar Association setting forth the manner in which a pre-trial commission or adjudication board might be organized and how it would function. The Board approved the plan in principle and instructed the Committee to continue its studies.

The following is a tentative outline of the proposed plan approved by committees representing the Medical Society and the D. C. Bar Association:

1. There should be a panel appointed to hear malpractice claims consisting of 2 doctors, 2 lawyers, and 1 member of the public selected by the 4 doctors and lawyers. The panel of doctors and lawyers to be selected in the following manner: Each society is to request its own membership to secure volunteers willing to serve on the panel; the president of each association shall then select approximately 25 persons who will be available the first year.

2. When cases arise, the 2 committees shall rotate the office of a secretary who can expedite the claim and set up the panel for arbitration. The Committee of the Bar Association shall designate men from a motions committee for the first 3 months to act as secretary to the panel on a particular claim, the next 3 months the Medical Society shall use its committee in the selection of a secretary, and so forth.

3. Appropriate rules of arbitration will be prepared as agreed.

4. A printed form for each case to be arbitrated shall be filled out by both sides to the arbitration, which will contain a statement of the case, an agreement to be bound by the arbitration, and this form shall be signed by both litigants and lawyers.

5. The arbitration proceedings shall be limited to interested parties and their witnesses.

6. The proposed arbitration shall determine and resolve both liability and in the event of an adjudication against a doctor, the panel may have the power to impose damages.

7. The proceedings, if possible, shall take place in a room made available at the new Federal Courthouse.

8. The testimony of the proceedings shall be transcribed.

9. Costs of the proceedings shall be borne by both parties as far as is possible. Efforts will be made to secure a sum of money from some foundation for use in a test of the arbitration proceedings.

10. The arbitration shall be final as far as the parties are concerned.

USF&G Professional Liability Insurance Coverage. It was not possible to hold this matter in abeyance for action by the Society at this meeting. Because most members renew their professional liability insurance policies on May 1, and no comparable coverage was offered at a lower premium rate, the Board voted to approve the recommendation of the Committee on Professional Liability Insurance that the coverage now available through the United States Fidelity and Guaranty Company be endorsed for another year. This action was taken with the understanding that every effort would be made by local representatives of the USF&G to eliminate the objectionable additional premium charge for partnerships. Representatives of the company have indicated that there is real possibility that this might occur in the near future. Following its approval of the Committee's recommendation, the Board directed a communication to all members notifying them of its action.

The Committee is continuing its efforts to obtain a group policy which will be satisfactory both from the standpoint of coverage and premium rates.

Appointment of Representatives to the Health Section of the United Community Services. Through an oversight this item was not included in the agenda sent members. As is customary at this meeting, the Board is pleased to submit for approval the following members' appointments to the Health Section of United Community Services for the year 1954–55:

Dr. Wallace M. Yater
Dr. Josephine Renshaw

Both Drs. Yater and Renshaw were appointed a year ago and with your approval will therefore succeed themselves.

Dr. Dart Appointed Director of Blood Center. The Committee on Blood reported that as of April 1, 1954, Dr. Raymond O. Dart had been made Regional Director of the Washington Regional Blood Center, American Red Cross.

Conclusion: Unless there is urgent business which requires prompt action by the Society the next business meeting of the Society will be held some time in the fall.

This year's SCIENTIFIC ASSEMBLY is sponsored jointly by the District Medical Society and the Medical Society of Virginia, and will be held at the Shoreham Hotel, November 1, 2 and 3. An unusually large attendance is already assured. All of the rooms at the Shoreham have been taken for the three days and there has been an overflow to nearby hotels. Everything points to an exceptionally successful meeting.

Respectfully submitted,
WALTER FREEMAN, M.D., *Chairman*
WILLIAM M. BALLINGER, M.D.
HUGH H. HUSSEY, M.D.
PRESTON A. MCLENDON, M.D.
WILLIAM ROSS MORRIS, M.D.
HERBERT P. RAMSEY, M.D.
WALLACE M. YATER, M.D.
THEODORE WIPRUD, *Secretary*

ANNUAL REPORTS OF MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA*

PRESIDENT'S REPORT

In meeting formally to review the completion of another successful year by Medical Service it is well for the Participating Physicians to realize that in this more than any other Blue Shield Plan they really exercise a controlling influence. Tonight this group will elect a new Board of Trustees, review and modify the fee schedule, and expose for study leading to suitable action any ideas whatever for the general betterment of the Plan.

Medical Service is a corporation acting as a depository of funds to furnish specified medical services by a coöperative group of more than 1,700 physicians serving more than 400,000 patients. Thus there is almost complete freedom of choice of physician by the patient. The Plan does not operate for profit, but it does insure "service benefits" to a large proportion of patients.

Medical Service is not just another insurance company. Physicians exercise a control over it which is intelligent and in the community interest. They have volunteered, as a major contribution to the Blue Shield movement, to render "service benefits" to subscribers who are under the income levels established by the Plan. What Medical Service pays a physician directly for service to a subscriber is of greater value to the patient in terms of benefits received than he himself could ever secure for the same amount of money. What the insured patient receives from a commercial insurance company is merely an indemnity to help him pay his total medical bill.

It would be completely wrong for the physicians of a Blue Shield Plan to let any other agency use its schedule with the same rights. Such a step inevitably would weaken the Plan by drawing away or keeping out a good risk group and it would diminish local control in the medical service field. The profit motive in some form must be present with the commercial carrier. The control of the service benefit in the community interest is the Blue Shield motive.

A very important aspect of the Medical Service benefit is that it insures only for physician services. This point must be clearly understood. We have during the early years, and somewhat for expediency's sake, paid hospitals directly for related medical services, even when rendered by non-physicians at times. This course is not sanctioned by our contract. An unfortunate sequela is that some hospitals have come to think they have legal claims upon Medical Service. This is well illustrated by the fact that when we recently tried to put into operation the experimental program of in-hospital medical care,* we were notified by the Hospital Council that they did not care "to participate in" this part of our program. Certain hospitals believed that not only had we failed in the duty to consult with them in setting up this program but that we should have sought their consent to modify certain schedules to cover services which are defined in our contract as the practice of medicine. It is likely that in the field of Ancillary Services our payment on legal assignments directly to hospitals of 72 per cent of all allowances in the past year is the big factor leading to lack of understanding of our proper position. The physicians in the related specialties of Anesthesiology, Pathology, Radiology, and Physiatry must accept a large share of responsibility for the failure of many hospitals and physicians to realize that Medical Service and Group Hospitalization have never at any time deviated from the basic principle that Blue Shield covers medical services while Blue Cross covers hospital services, and further that all of these "ancillary" services are the practice of medicine.

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* These reports were submitted by the President, Manager, and Chairman of the Committee on Physicians' Services, respectively, before the Sixth Annual Meeting of Participating Physicians of Medical Service of the District of Columbia, in the District Medical Society's Building, April 28, 1954.

The failure of Medical Indemnity of America to appreciate the importance of this last point in writing Blue Shield contracts on a national basis was the reason for the Special Conference of Plans in January of this year. One result of this conference seemed to be some general shifting in the direction of recognizing that all of these related medical services should be covered by Blue Shield. It would be tragic for us to take the backward step of losing some of this principle locally because of the failure of the physicians themselves to support it and at the very time the national picture is changing in the other direction.

This problem was recently presented to a special meeting here of representatives of these related medical fields. It was pointed out that all Participating Physicians have something at stake in preserving proper separation of Blue Shield-Blue Cross coverage. In this connection the limitations imposed upon Medical Service should be well understood. Medical Service is not organized to control the form of practice but to provide that which is customary in the community. Medical Service cannot prevent assignment of collection rights by any physician. We can ask for periodic reassignment of these rights as so many of them are now made at hospitals. We could require the physician's signature on each claim before honoring it. When we indemnify a patient directly because he did not receive the physician service to which he is entitled under the Plan we can explain this fact to the patient. But, all these things demand a coöperative effort by the big body of Participating Physicians.

Another aspect of our present payment only for physician services is the request that we change our original policy as stipulated in our Certificate of Incorporation, our By-laws, and our subscriber Certificate and Physician Agreement, and that we now begin to cover for non-physician services. If such a change were made it would certainly have to include Dentistry and perhaps Osteopathy and other related groups with Podiatry. While we recognize the competence of certain individuals in these fields, the fact that we have no means of selection on the basis of ability but would have to accept all the groups involved would seem to make any move in this direction impossible under our present contract without great danger to the Plan.

The question of fees will occupy much of our attention tonight. The nonprofit nature of our operation insures that average fees will be as high as the premium rate will permit. Low operating cost and additions to reserves at the lowest rate consistent with safety are factors leading to a relatively high schedule in relation to Plan income.

We must realize that schedules are based on averages. The unusual case is never adequately covered while some are covered more than adequately. We plan to consider the problem of multiple policy coverage by some subscribers when we make our next contract revision.

Extended coverage is one of the big problems in all plans. Big items are the important ones to the affected patients. The small, high frequency items are the costly ones for the Plan. Deterrents against promiscuous utilization are badly needed as financial safeguards. The deductible feature in our medical care program is therefore a very important factor to evaluate. Sound insurance principles must be followed if Plan expansion is to avoid disaster.

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* This program, approved at the 1953 annual meeting, and publicized subsequently in communications directed to Participating Physicians, provides coverage of certain physician's services for medical conditions in hospitalized patients.

Specific recommendations have been made to cover:

1. Congenital defects
2. Multiple procedures more fully
3. Delivery fees more adequately
4. Radiation therapy in cancer

All of these have been carefully considered and found to be economically impractical under the present program. Now, however, more than ever we face the need for more comprehensive contracts and all these things and many more will be reviewed by the new Board that you elect tonight. Our recent efforts to expand have been in the direction of the medical care program and these will be pursued.

One recent educational step which needs modifying was the letter explaining the value of Group Hospitalization, Inc. and Medical Service to the patient. It has been discontinued pending acceptance of a better form but we hope it can be revived.

The highest praise is due all members of the Board and the committees of Medical Service. All give freely of their time. They are a truly dedicated group whose reward is a job well done. The new, enlarged Board will include certain additional areas of service but not narrow, partisan ones.

I can do no better than to close this report by a quotation from the one last year:

"Although the physician's primary obligation is to his patient, and although Medical Service does not intrude between the two in an individual case, the long-range interest of both is best served by a strictly objective adherence to the standards set up for the Plan. It must be remembered that whenever, by the efforts of patient or physician, any payment is made improperly, this loss must be shared by all; but the greater loss will be to the morality which must guide such undertakings as this.

"No double standard of morality will do here. It cannot be assumed that it is fair to 'get something' from an institution, if possible, or that it is not *too* wrong for an institution to take a *little* advantage of an individual. In a truly coöperative enterprise the Golden Rule must apply not only between individuals but between any individual and his institution.

"The public and all physicians must be guarded from incompetent or unscrupulous behavior by the occasional individual or institution. Such guardianship is largely the responsibility of the Participating Physicians. The Plan is powerless from the administration side alone.

"The Plan can and should join with such groups as medical societies and lay subscriber groups to give information and guidance along these lines. The elevation of medical standards is important to us all. The problem is one of education. Based on proper information action will be suitable.

"This then is the physician's own Plan. His personal freedom in it will grow with his self control under a high morality. Since the morality of the profession is high, the benefit to the patient is assured. The development of these ideals of coöperative function is the goal of the next period for Medical Service."

DONALD STUBBS, M.D., *President*

REPORT ON ADMINISTRATIVE SERVICES

With the continued steady growth of Medical Service, it is a pleasure to report that the cost of operating the Service was reduced once again in 1953.

I am sure you will recognize that the addition of 38,000 participants, a corresponding increase in billing and accounting services, and the resulting number of claims to be processed and paid to Participating Physicians have created a demand for ever-increasing attention to detail and refinement of administrative processes.

I would like to speak to you about enrollment. As of December 31, 1952, Medical Service had 366,000 participants enrolled in the Plan and, at the end of 1953, there were 404,000 participants enrolled, a net gain of 38,000 participants for the year. It is interesting to note that, while the potential enrollment is constantly diminished each year by the addition of new participants, the net enrollment for 1953 nearly approximated that of 1952. Medical Service ranks eighteenth in total enrollment among the 76 approved Blue Shield

Plans, most of which operate on a state-wide basis, and ranks second in the percentage of population enrolled, a record it has held for the past several years. Some of our satisfaction in our enrollment progress must be tempered, however, by recognition of the fact that 49,000 participants cancelled their protection for various reasons, and it was necessary to enroll 87,000 new participants in order to obtain a net gain of 38,000 for the year.

The prepayment of medical expense has become a recognized part of our way of life, and more and more employers are contributing to the cost of the employee's health benefit coverage. Approximately 15 per cent of the subscribers enrolled in commercial groups have all or part of their contract paid for by their employers. In 1953, 59 new groups were established, in which the employer contributed to the cost of coverage, and 42 groups changed over from payment by the individual to contribution by the employer. It is to be hoped that efforts to acquaint the public with the unique features of Medical Service of D. C., and a continued demonstration of the manner in which physician participation provides benefits which could not be obtained otherwise, will reduce the number of cancellations in the coming year and help to combat increased efforts on the part of commercial companies to obtain control of the prepayment health service field.

Claims Management

New subscribers inevitably contribute to an increase in the number of claims to be processed, and we received 103,473 claims for services rendered in 1953, an increase of 18.8 per cent over the number of claims for services rendered in the preceding year. Of course, an increase in the number of claims can be directly attributed to an increase in the number of subscribers, but it is significant that the claims payment per thousand participants increased 5.8 per cent over the 1952 figure, an indication of increased use of Medical Service benefits on the part of the public. It is also interesting to note that, despite an increase of 18 per cent in claims received, the number of claims rejected remained substantially the same. This liberalization of claims payment on the part of management is a reflection of the attitudes of the Board of Trustees and the Physicians' Services Committee, and is evident in many other aspects of the administration of Medical Service.

Not only was there an increase in claims processed in 1953, but the speed with which payment was made was increased. We are now able to process claims nine days faster, which means payment is received by the physicians that much sooner. With a typical claim today, payment is generally made within a week, or two weeks after the doctor's report is received in our office. The handling of more claims in a shorter period of time was brought about by devising better methods of keeping records, and omitting information from our records which was not absolutely necessary. In addition to internal changes, we designed a new Physician's Service Report which added greatly to the efficiency of claims processing.

The processing of 412 claims every working day is an intricate and potentially expensive task, which is being carried out efficiently and at a minimum of expense in order that an increasing amount of the subscriber's dollar may be allocated to payment to physicians and the establishment of reserves.

Operating Costs

I am sure that every doctor participating in Medical Service is anxious to know that his Plan is being administered efficiently and economically. It is certainly the desire of the Administration to conserve the funds of Medical Service, and the record once again indicates that we are making a successful effort in this direction. In 1952, 9.5 per cent of the Plan's income was utilized for operating expenses; in 1953, only 8.9 per cent was used for this purpose. The average for all Blue Shield Plans in 1953 was 11.33 per cent. Each year since Medical Service began operating, the percentage of income required to administer the Plan has been reduced. Great economies in operation are provided by our working agreement with Group Hospitalization, Inc., which permits employees of Group Hospitalization to process a Group Hospitalization and Medical Service account simultaneously in many instances, and to share the expense of facilities which would be more costly for both Plans if borne separately. There are, however, certain aspects of the administration of Medical Service which cannot be conducted by lay personnel, and I am grateful for this opportunity to emphasize the value of the services rendered by physicians who have devoted many hours to the consideration of claims, medico-legal problems, fees, and those aspects of the Plan's operation which are dependent upon medical understanding.

Participating Physicians

At the present time, there are 1,700 physicians participating in Medical Service. Undoubtedly, a number of physicians arranged to participate in Medical Service because of the In-hospital Medical Care Program, and I regret I am not able to provide you with more encouraging figures about the progress of this program. Interest in the program has been indicated by a number of prospective groups but, because some of the services to be covered are sometimes under the control of hospitals which are not sympathetic to the program, we have not been able to guarantee that the benefits offered can be provided, and enrollment has been curtailed temporarily. A new group was established for an effective date of February 1, and another for a March 1 effective date. We hope to be able to devote greater effort to the enrollment of subscribers in this program in the very near future, and it is to be expected that physicians who render this particular type service will continue to express their desire to become Participating or Coöperating Physicians.

The fine support which Participating and Coöperating Physicians have given Medical Service in the past has been most heartening, and has contributed greatly to the smoothness and efficiency of the Plan's operation.

It is important that the public be provided with a means for prepaying the cost of a physician's services. It is also important that the public rely on a prepayment program which reflects the confidence of the patient's physician in the Plan in which he participates. It is still more important that the Participating Physician demonstrate his support of a medically-sponsored program by recommending it to his patients and giving evidence of his participation in it. With that thought in mind, your Board of Trustees has authorized the distribution of a wall plaque, signifying the physician's participation in Medical Service. This plaque will be furnished without charge to all Participating and Coöperating Physicians who wish to display it. A card will be sent to you soon for your use in requesting the plaque for display in your office.

In the final analysis, it is the participation of physicians, both in action and in spirit, which determines the extent to which we are able to carry out our objectives, and we in the Administration recognize and appreciate your help.

George B. McGovern, *Manager*

REPORT OF COMMITTEE ON PHYSICIANS' SERVICES

Medical Service was established in April 1948, and its Physicians' Services Committee began functioning during the same year with 3 members. The Committee was later enlarged to 6 Participating Physicians, and, in May 1952, it was increased to its present number of 9 physicians.

The members of the Committee represent the following branches of medicine: 2 members from General Surgery, and 1 member from each of the following: General Practice, Obstetrics and Gynecology, Urology, Orthopedics, Plastic Surgery, Neurosurgery and Ophthalmology. For each member of the Committee there is an alternate member, except in the case of Plastic Surgery. Hence, there are 9 regular and 8 alternate members who conduct the work of the Physicians' Services Committee in conjunction with Dr. A. Clagett Gray, the Medical Advisor of the Plan, and Mr. McGovern and Mr. Carpenter of Medical Service, who are present at all Committee meetings.

The duties of the Committee and the term of service of each member can best be explained by quoting an excerpt from the By-laws of Medical Service: "The Board of Trustees shall appoint nine Participating Physicians for a term of three years. The function of this Committee shall be to protect the interest of the subscribers and the physicians. The Committee will review and approve payment of bills other than those of a routine nature submitted by physicians for services rendered to subscribers. It will review and adjudicate complaints involving patients and physicians. An appeal may be made from any decision of the Committee to the Board of Trustees, whose decision shall be final. Such appeal shall be filed in writing within ten days after the decision of the Committee has been served or mailed to the interested party or parties."

From April 1953 to April 1954 the Committee held 9 meetings involving a total of 24 hours, an average of 2.66 hours per meeting. The attendance averaged 6 members. The Committee considered 261 cases, the decisions in 6 of which were appealed to the Board of Trustees. The Committee made 2 recommendations to the Board of Trustees and suggested a number of changes to the Committee on Fees of Medical Service. On one occasion, the Chairman of the Physicians' Services Committee attended, by invitation, a meeting of the Committee on Fees.

Some of the problem claims presented to the Committee, with examples, might be classified as follows:

1. *Determining the eligibility of a subscriber to receive benefits from Medical Service during the first 10 months of participation.*

a. The patient's contract became effective January 1, 1953, and 2½ months later the patient became aware of a lump in the neck. At thyroidectomy, multiple adenomata of the gland were found. The Committee decided the condition preëxisted the effective date of the contract and recommended disallowance of the claim. Many times the patient, and sometimes the physician, feels that because the first symptom became evident after the effective date of the contract, the claim should be allowed. It is recognized that many diseases do not produce symptoms until some time after their onset.

b. A hemorrhoidectomy was performed because of profuse bleeding 2½ months following the effective date of the contract. The hospital record indicated the patient had had hemorrhoids for 5 years. This claim was not approved because of preëxisting disease, the bleeding being considered a complication.

c. This patient's contract became effective January 1, 1953, and 5 months later surgery was performed for ruptured gall bladder with stones. The Claims Department had rejected this case for payment on the basis of a preëxisting condition. The case came to the Committee because of an appeal by the surgeon. The Committee decided it was impossible to determine whether the condition preëxisted the contract date, and the ruptured gall bladder, which was the factor precipitating surgery, could not have preëxisted. The Committee therefore recommended payment of the claims.

2. *Problems concerning complications of surgical operations.*

a. In this case, a subtotal gastrectomy had been performed for duodenal ulcer. On the following day, the patient was reoperated for acute pancreatitis. The claim for the second operation was disallowed by the Committee, who felt it was performed for treatment of a complication of the subtotal gastrectomy.

b. A diabetic patient had a cataract removed from the left eye. A week later, the same eyeball was enucleated because of infection. The Committee considered the second operation was performed to treat a complication of the original surgery and did not approve the claim for the second operation.

c. The patient had a D & C and cervical biopsy. A week later, severe hemorrhage occurred and suture of the cervix was required. No compensation was allowed for the second procedure for the same reason.

In a few instances, it has seemed difficult to deny compensation for the surgical treatment of operative complications over which the surgeon may have no control. The surgeon is obligated to treat complications as part of his contract with the patient. However, the Schedule of Fees is based on the average rather than on extraordinary cases and the Committee is obligated to rule in accordance with the provisions of the contract.

3. *Multiple operations for the same condition.*

a. The patient had, within 10 months, 2 operations for excision of pilonidal sinus. The Committee disallowed the claim for the second operation because it was performed for the same condition.

b. In another case, the surgeon had been paid the full fee for transurethral resection of the prostate. Four months later, the patient had a second transurethral resection. The second claim was denied. According to the Schedule of Fees, this operation carries with it release for further claims for surgery of the prostate.

c. A laminectomy with excision of intervertebral disc was performed. Within 3 weeks the same surgeon reexplored the same area because of recurrent disc. The Committee decided the second procedure had been done for the same condition and rejected the second claim.

4. *Establishment of fee for multiple operations by one or more surgeons at the same or different times and through the same or different incisions.*

a. Following delivery of the baby, the patient suffered shock due to hemorrhage. A second physician was called to remove the placenta. On the basis of a total allowance of $80 for deliveries, the Committee decided the first physician who delivered the baby should receive $45 and the second physician $35 for removal of the placenta.

b. This patient had a splenectomy and developed postoperatively pleural effusion and subphrenic abscess. A second surgeon relieved the effusion by thoracentesis and drained the abscess by paracentesis. The patient had multiple procedures, 2 surgeons were involved, and the effusion and abscess might be considered complications of the splenectomy. The Committee decided, however, that the second surgeon was entitled to the full fee for thoracentesis and one half the usual fee for paracentesis.

5. *Establishment of fees not listed in the Schedule of Fees.*

a. The surgeon had excised a fibrosarcoma of the foot including complete removal of the plantar fascia. A fee of $100 was established for this operation.

In establishing fees for unlisted operative procedures or for variations of already listed operations, the Committee takes into consideration a number of factors, such as the duration of operation, the operative record, the risk involved, the scheduled fees for comparable operations, etc.

6. *Claims for procedures or conditions not covered under the Plan.*

a. The Committee decided in considering a claim for perianal alcohol injection for pruritus that the procedure was not surgical and no allowance was recommended.

b. Another claim for excision of a nevus on the nose was rejected on the basis that the condition was congenital.

7. *Claims for operations to produce sterility.*

The Plan has not approved claims for sterilization procedures unless performed for valid medical reasons. Each case has been individually considered upon its own merits. The Committee has had difficulty in specifically defining the term "valid medical reason" and is cognizant of the numerous public relations and medico-legal problems involved. The Committee feels that Medical Service should eliminate coverage for sterilization operations.

8. *Miscellaneous cases.*

The Committee is obligated to protect the interests of both the subscribers and the physicians. Its rulings must be governed by the terms of the contract and the Schedule of Fees wherever possible. The Committee seldom questions the integrity of the Participating Physician, but it does feel it has the right to exercise some judgment in its decisions to avoid excessive costs to the Plan as might be incurred by claims for procedures previously performed and paid for, unnecessary surgery, inaccurate operative records, elaborate descriptions of operative procedures, etc.

a. A surgeon performed a laparotomy, appendectomy, D & C, and cauterization of the cervix. A week later, the patient had a hysterectomy for fibroids. The Committee approved payment of the fee for the hysterectomy only, the major of the two operations. It was felt that a vaginal examination would have revealed the presence of fibroids and the patient need not have had two laparotomies.

b. A claim for skin graft to close a radical mastectomy wound was rejected. Closure of the wound was considered by the Committee to be a necessary part of the mastectomy operation.

c. A surgeon submitted two claims for fistulectomy. In his letter of appeal following rejection of the second claim, he explained he performed a two-stage fistulectomy to avoid incontinence from a nonfunctioning anal sphincter. It was obvious to the Committee that the first operation was incision and drainage of abscess and the second was fistulectomy. The claims were approved on that basis.

d. This patient changed physicians after reduction of his fracture. The second physician removed the cast in his office and applied another cast. The claim for the services of the second physician was rejected. Payment for reduction of the fracture had been made to the first physician. The patient had elected to change doctors and therefore should be responsible for paying for the services of the second physician.

9. *Claims involving multiple laboratory tests for an amount of money far in excess of the surgical fee.*

This was a new problem to the Committee this year. Since the Committee is authorized, under a provision of the Schedule of Fees, to determine the allowance to be made when 2 or more procedures are performed at different times for the same condition, it fell within the province of this Committee to recommend a solution to this problem.

There were 10 such cases, 4 from each of the 2 medical university hospitals and 1 from each of 2 local community hospitals. I should like to give a brief partial résumé of several of these claims.

a. This patient was hospitalized 231 days. The final diagnosis was cardiovascular disease and the surgery was prostatectomy. The total claim for laboratory services amounted to $1,962. Some of the tests were: 83 chemistries and 73 sensitivity tests at $5 each; 43 chlorides and 16 sodiums at $5 each; 18 potassiums at $8 each; 50 CO_2 combining powers and 24 blood urea nitrogens at $5 each; 15 cultures at $5 each; and 18 prothrombins at $3 each.

b. This patient was still in the hospital after one year. The final diagnosis was periarteritis nodosa, anemia and diabetes. Two surgical procedures had been performed at different times, a D & C and splenectomy. The total claim for laboratory tests was $1,851. Some of the tests were: 941 diabetic tests at $1 each; 22 serum proteins at $10 each; 21 zinc sulfate turbidity tests at $5 each; 19 glucose and 23 hemograms at $5 each; 22 sedimentation rates at $3 each; and 10 occult blood tests at $1 each.

c. This case was admitted to one hospital for 18 days and transferred to another for 1 month. The diagnosis was pyelonephritis. Two cystoscopies were performed and a transplantation of ureters. The laboratory claim amounted to $187 from the first hospital and $577 from the second, a total of $764.

d. The other cases presented claims for laboratory tests as follows: $702; $664; $524; $400; $119; and $85.

The Committee felt that these cases presented a serious financial problem to the Plan and that more such claims would arise in the future. A meeting with invited representatives of the medical and surgical departments of the university hospitals was devoted to a discussion of these claims. Some of the principal points of this discussion should be mentioned.

1. Medical Service furnishes coverage for laboratory tests directly related to the surgery performed. Many of the tests in these cases were not directly so related.

2. Such cases may be more frequently encountered in university hospitals, as more difficult cases may gravitate there.

3. Such problems can be expected to increase with the advent of new laboratory tests which will become standard procedures for accurate diagnosis.

4. It was thought advisable to include in the curricula of medical schools and intern training programs instruction in medical economics and problems of voluntary medical insurance plans.

5. The establishment of a limit on laboratory charges would discourage the ordering of unnecessary tests, but insurance plans should consider provisions for catastrophic illness.

6. Any negotiations in these cases should be conducted with pathologists rather than hospital administrators, since Medical Service has agreements only with physicians.

The Committee carried out a study of the Plan's claims for December 1953. The total claims expense was $356,659, of which $21,750, or 6.09 per cent, represented laboratory expense (1,712 laboratory claims). Of the total laboratory expense ($21,750), $4,305, or 19.79 per cent, was expended in claims in which each case had a laboratory claim of over $50.

For those cases which were considered individually the Committee adopted a working rule that it should not approve claims for laboratory services in excess of the surgical fees. Each of these cases was individually considered and a decision was reached to approve payment of a fee less than that stated in the claim.

Of the 261 cases considered by the Physicians' Services Committee during the past fiscal year, 6 cases were appealed to the Board of Trustees. In 4 cases the decision of the Committee was sustained, in the fifth a higher fee was allowed, and the sixth claim was referred back to the Committee for reconsideration.

The Committee made 2 recommendations to the Board of Trustees: One concerned the limitation of fee in a specific case of multiple operations—the electrocoagulation and excision of more than 150 sebaceous cysts. The other recommendation was that sterilization operations be excluded from the contract at its next revision.

The Chairman would like to express his appreciation to Dr. A. Clagett Gray, Mr. George McGovern, and Mr. Arthur B. Carpenter, who have so ably assisted the Committee in all its deliberations. He also wishes to pay tribute to the regular and alternate members of the Committee for their attendance, loyal support and long hours of labor, and particular tribute to Dr. Edward Nicklas, Dr. Robert Moran, and Dr. Sterling Bockoven, whose terms of the Committee membership expire.

J. OGLE WARFIELD, JR., *Chairman*

BOOKS RECEIVED

Acknowledgment is made of the following books which have recently been received. Selections will be made for more extensive review in the interests of our readers and as space permits. Physicians are urged to submit reviews of additional current books which, in their opinion, merit comment.

A Curriculum for Schools of Medical Technology, 3rd ed., recommended by the Board of Registry of the American Society of Clinical Pathologists. ISRAEL DAVIDSOHN, M.D., Editor; Professor of Pathology and Chairman of Department, Chicago Medical School; Director of Laboratories and Pathologist, Mount Sinai Hospital; Director of Research, Mount Sinai Medical Research Foundation, Chicago, Illinois; AND KURT STERN, M.D., Associate Editor; Director, Blood Center of Mount Sinai Medical Research Foundation and Hospital; Assistant Professor of Pathology, Chicago Medical School, Chicago, Illinois. Price, paper, $3.00. Pp. 122 Muncie, Indiana: Registry of Medical Technologists (P. O. Box 1209), 1954.

Global Epidemiology: A Geography of Disease and Sanitation. Volume III. The Near and Middle East. JAMES STEVENS SIMMONS, B.S., M.D., PH.D., DR. P.H., SC.D. (Hon.), Brigadier General, United States Army, Retired; Dean and Professor of Public Health, Harvard University School of Public Health; TOM F. WHAYNE, A.B., M.D., M.P.H., DR. P.H., Colonel, M.C., United States Army; Chief, Preventive Medicine Division, Office of The Surgeon General, United States Army; GAYLORD W. ANDERSON, A.B., M.D., Dr. P.H., Mayo Professor and Director, School of Public Health, University of Minnesota; HAROLD MACLACHLAN HORACK, B.S., M.D., Member of Staff, Department of Medicine and Section of Cardiology, Ochsner Clinic, New Orleans; Instructor in Medicine, Tulane University School of Medicine. Associate Author: RUTH ALIDA THOMAS, B.A., A.M., M.P.H., Research Associate, School of Public Health, University of Minnesota; Instructor, Department of Tropical Public Health, Harvard University School of Public Health, AND COLLABORATORS. Price, $12.00. Pp. 357, illustrated. Philadelphia: Lippincott, 1954.

Geriatric Medicine—Medical Care of Later Maturity, 3rd ed. Edited by EDWARD J. STIEGLITZ, M.S., M.D., F.A.C.P., Consulting Internist, Suburban Hospital, Bethesda, Md., and Washington Home for Incurables; Chairman of Staff, 1945–1947, Suburban Hospital, Bethesda, Md.; Consultant in Geriatrics, Chesnut Lodge, Rockville, Md., St. Elizabeths Hospital and Veterans Administration; Associate, Washington School of Psychiatry; Lecturer in Industrial Medicine, New York University-Bellevue Post-Graduate Medical School; Chairman, Advisory Council on Professional Education, Commission on Chronic Illness; Consulting Editor, *Geriatrics*; Formerly Associate Clinical Professor of Medicine, Rush Memorial College, University of Chicago; Washington, D. C. Price, $15.00. Pp. 718, with 205 figures. Philadelphia: Lippincott, 1954.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, April 26, 1954, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society.

Active Members

George A. Courie, 1540 Hemlock Street, N.W.
Walter Lester Henry, Jr., 4625 Blagden Avenue, N.W.
John B. Johnson, Howard University
Marion E. Maclean, 647 Maryland Avenue, N.E.
William Newman, George Washington University Hospital
George P. Petropoulos, 1150 Connecticut Avenue, N.W.
Lawrence V. Phillips, 2316 Naylor Road, S.E.
Stacy L. Rollins, Jr., 1150 Connecticut Avenue, N.W.
Joseph W. Still, 1300 19th Street, N.W.

Associate Members

Martha Ray Lumpkin, 2800 Quebec Street, N.W.
Guilford E. Naranjit, 627 14th Street, N.E.

Resident-Intern Members

Robert N. Snider, 7705 Greeley Road, Hyattsville, Md.
Edward S. Witowski, Jr., 5606 Massachusetts Avenue Extended

The following applicants for membership will be voted on at the meeting of the Executive Board, July 26, 1954.

For Active Membership

Thomas L. Auth, Georgetown University—1948
Charles J. Everding, George Washington University—1950
Robert C. Hill, Hahnemann Medical College—1942
Ross M. Lehman, Jr., Georgetown University—1947
James C. Mandes, George Washington University—1950
Mary Jane O'Leary Matthews, George Washington University—1949
Jay C. Maxwell, Duke University—1948
Howard Otis Mott, George Washington University—1944
John J. Nolan, University of Pennsylvania—1945
Sam C. Pascoe, Vanderbilt University—1950
Raymond Stoller, George Washington University—1946
Robert B. Sullivan, Georgetown University—1944

For Associate Membership

Harold T. Dodge, Harvard University—1948
John Martin, Northwestern University—1935
Gertrude Ungar, University of Vienna (Austria)—1927

(*Continued on page 362*)

On the Lighter Side

The pages of the MEDICAL ANNALS usually are filled with the comings, the goings and doings of our medical confreres. Today, however, we are dedicating this page to those courageous women who were brave enough to "marry up" with these brethren, and who have found the time in their busy lives to keep their minds alert and their muscles strong by bowling.

The Woman's Auxiliary to the Medical Society Bowling League has finished another successful season and the following teams finished in the order named with their wins and losses:

Team	*Captain*	*Won*	*Lost*
12	Mrs. Carol Montgomery	41	16
4	Mrs. Sunny Morris	40	17
9	Mrs. Mary Duchez	34	23
6	Mrs. Ann McDonald	32	25
14	Mrs. Tommy Steptoe	32	25
19	Mrs. Jane Price	30	27
5	Mrs. Helen Marie Doland	30	27
13	Mrs. Alma Kirchner	28	29
15	Mrs Rebecca Hodge	28	29
11	Mrs. Jane Evans	27	30
10	Mrs. Phyllis Buxton	27	30
8	Mrs. Annie Mae Daly	27	30
1	Mrs. Marian Belair	27	30
16	Mrs. Irma Hobart	26	31
18	Mrs. Helen Preece	25	32
20	Mrs. Wealthy Reisinger	25	32
7	Mrs Lydia Ballinger	25	32
17	Mrs. Jean Irey	25	32
2	Mrs. Jean Veal	22	35
3	Mrs. Lore Irey	19	38

The high individual average of 96, the high individual game of 138, the highest number of spares 78, and the highest number of strikes 14 were won by Mrs. Helen Marie Doland.

The highest individual set of 343 was rolled by Mrs. Joan Dorman, who also tied Mrs. Doland with 14 strikes. Mrs. Polly Stow rolled the second highest individual game of 132, and also knocked down the second highest number of spares with 68. Mrs. Mary Smith tied the two leaders for highest individual strikes with 14, and Mrs. Pearl Gates picked off 64 spares to come in third in that department.

In a less spectacular role was Mrs. Phyllis Buxton, who rolled the highest flat game of 94. This is no mean accomplishment and reveals accurate pin clipping by Mrs. Buxton.

The greatest improvement for a new bowler fell to the lot of Mrs. Pinky Sjogren, who rolled a low 62 as an entering average, but who picked up finesse and know-how during the bowling season to end up with a decent 79-47 as a final average. The greatest improvement for the league bowler who has bowled two consecutive years was noticed in Mrs. Tommy Steptoe, who entered the bowling competition with a 70 in 1952 but who finished the season 1953-54 with 80-11.

The members of the D. C. Medical Bowling League who have been encouraging their wives to participate in the Woman's Auxiliary Bowling League, and who have been instructing them in the fine art of sweeping the pins off the boards, should feel pride in the accomplishments of our lady bowlers. In fact, we men who have never been able to advance much farther than halfway up in the D. C. Medical Bowling League's standing have been tempted to smuggle such bowlers as Mrs. Helen Marie Doland into our League in order to help us win a few games.

GOLF NEWS: Dr. Leonard Berman won the Dr. Charles Birdsall Golfing Trophy recently at Kenwood by being low gross winner in the Mid-Atlantic Branch of the American Urological Association golf tourney. Dr. Berman shot an 80. Dr. Robert Byrne had a 72 for net honors, and Mrs. Roland Gable (where was Roland?) won the women's gross prize with a 94.

Forty-five urologists from Pennsylvania, Maryland, Virginia, West Virginia, Delaware, and the District of Columbia competed for the prizes.

Dr. Charles Birdsall's widow presented the silver cup to Dr. Berman. Dr. Birdsall was the former Professor of Urology at the University of Pennsylvania.

TODAY'S THOUGHT: Success—making more money to meet obligations you wouldn't have if you didn't have so much money (anon.).

J. EARL KADAN, M.D.

News and Personals

MEETINGS—Past and Future

The Inter-Society Cytology Council will hold its second annual meeting in Boston, November 12 and 13, 1954. Those having material to present are invited to submit three copies of the title and an informative abstract of not more than 200 words to Dr. John B. Graham, 32 Fruit Street, Boston, Mass., before July 15. Abstracts of all papers accepted will be published in the official program. Papers will be limited to 15 minutes and will be discussed in related groups rather than individually, a maximum of 8 papers to be presented to each session. Particular attention is suggested for the endometrium and lesions of the gastrointestinal and urinary tract. The authors of papers selected for presentation will be notified by September 30, 1954.

Physicians are urged to make their reservations directly with the Reservations Manager, Statler Hotel, Boston, Mass. Registration will be open to anyone interested in cytology. Registration fee for physicians is $5; for cytologic-technologists, technicians, and others, $2. Medical students, interns, and residents will be admitted without charge. For additional information please write the Secretary-Treasurer, Inter-Society Cytology Council, 634 North Grand Blvd., St. Louis, Missouri.

The program for the **Eastern Conference of Radiologists**, which was held at the Hotel Statler, March 12 and 13, listed a number of papers by members of the Section on Radiology of the District Medical Society, which was one of the sponsoring organizations. Other constituent organizations for the Conference were the Section on Radiology of the Baltimore City Medical Society, the New England Roentgen Ray Society, the New York Roentgen Society, and the Philadelphia Roentgen Ray Society.

Among papers presented by members of the District Medical Society were:

"The Correlation of the Radiological, Pathological and Clinical Facts of Diverticulitis," Drs. Alexander Goulard, Jr., and Aubrey O. Hampton

"Evaluation of Placentography in Late Bleeding of Pregnancy," Dr. Eugene J. McDonald

"Carcinoma of the Cervix Treated by Intra-arterial Aureomycin and Irradiation," Dr. Charlotte Donlan

"The Internal Architecture of the Femur from the Orthopedic and Radiological Standpoints," Dr. William J. Tobin

"Observations on Periarthritis Calcarea and a Reëvaluation of the Tennis Elbow Syndrome," Dr. Bela Gondos

"Interesting Features of Hereditary Diseases in Bone Pathology," Dr. W. E. Baensch

"The Significance of Breech Presentation with Fetal Opisthotonos," Dr. Robert B. Nelson, Jr.

"Some Roentgen Characteristics of Benign Gastric Ulcers," Drs. Aubrey O. Hampton, Forrest Schumacher, and Clemmer M. Peck

"Reticuloendothelioses in Children," Dr. Isidore Lattman

"Radiological Detection of Biliary Calculi," Dr. Russell B. Diley

Dr. Ralph M. Caulk participated in a Panel Discussion on the Clinical Uses of Radioisotopes at the morning session, March 12.

Dr. Alfred A. J. Den, Chairman of the D. C. Section on Radiology, presided at the morning session, March 12; Dr. David H. Rosenfeld, Vice Chairman, presided at the afternoon session; and Dr. Joseph F. Belair was the presiding officer at the concluding scientific session on Saturday morning. Dr. Karl C. Corley was Chairman of the Local Committee on Arrangements.

The Mid-Atlantic Section of the American Urological Association held its Annual Meeting at the Shoreham Hotel, April 22, 23 and 24. Dr. Horatio N. Dorman, President of the Section, gave his Presidential Address at the afternoon session, April 23; his subject was "Where Are We Going?" Following his address, Dr. John A. C. Colston, of Baltimore, President of the American Urological Association, spoke on "The Journal of Urology."

In addition to Dr. Dorman, four other members of the District Medical Society took part in the scientific program. Dr. Clifford E. Bagley (Associate member) and Dr. Michael A. Puzak, of Arlington, Va., presented a paper on "One-stage Suprapubic Prostatectomy." Dr. Roger Baker, Professor of Urology, Georgetown University School of Medicine, was invited to address the Section on "Hemicystectomy versus Segmental Resection in Treatment of Bladder Cancer." Drs. Lloyd G. Lewis and J. E. Ash discussed a paper on "Mucous Adenocarcinoma of the Urinary Bladder with Related Lesions" by Dr. F. K. Mostofi of the Armed Forces Institute of Pathology.

The Washington, D. C. Academy of General Practice presented an all-day Symposium on Trauma at the Hotel Statler, May 6. Dr. Lewis A. Klein, President of the Academy, was moderator at the morning session and also presided during the luncheon program; Dr. Maurice J. Kossow, Vice President, was moderator for the afternoon session.

Dr. Brian Blades, Professor of Surgery, George Washington University School of Medicine, the first afternoon speaker, discussed "Injuries to the Thorax." Colonel John Martin, Chief of Neurosurgery, Walter Reed Army Hospital, presented a paper on "Early Care of Craniocerebral Injuries." Other guest speakers were from out-of-town. The luncheon address was given by Dr. Elmer Louis Kayser, Dean of Students at George Washington University.

Lederle Laboratories Division of the American Cyanamid Company was co-sponsor of the symposium.

The 17th Annual Meeting of the Medical Society of Saint Elizabeths Hospital was held in the Geriatric Building of the Hospital, April 23 and 24. Most of the participants in the scientific program were Active or Associate members of the District Medical Society. They furnished the following papers:

"Theoretical and Practical Considerations of Interstaff Group Therapy," Drs. Edward M. Pickford and Anthony Zappala

"Changes in Electro-encephalographic Records during Psychotherapy: Report of a Case," Dr. Michael A. Woodbury

"Classification of Sexual Disorders," Dr. Leon Salzman

"Countertransference: Its Influence on a Patient's Capacity for Awareness," Dr. Daniel S. Jaffe

"The Nature and Psychiatric Challenge of D. C. General Hospital," Dr. Christine W. Kehne

"Epigain and Endogain: The Secondary and Primary Gains in Emotional Illness," Dr. Henry P. Laughlin

"Notes on Therapy of Acute Paranoid Psychosis," Dr. Maxwell Boverman

"Emotional Illness in Husbands Precipitated by Pregnancy," Dr. Arcangelo D'Amore

On Saturday afternoon, Dr. Winfred Overholser, Superintendent of the Hospital, was moderator for a Symposium on the Calculated Risk Patient. Dr. Zigmond M. Lebensohn presented the legal aspects and Dr. Isadore Rodis, the therapeutic aspects. Other participants in the symposium were Drs. Jay L. Hoffman and Morris S. Schwartz.

Among discussants of papers were Drs. Joseph Abrahams, Harvey Ammerman, Robert C. Burnham, Addison M. Duval, Ben Karpman, Reginald S. Lourie, Manson B. Pettit, Francis J. Tartaglino, Edith Weigert, and Leon Yochelson.

Dr. Norman Taub was chairman for the morning session, April 23. Dr. William L. Granatir, President of the Society, presided in the afternoon, and Dr. Duval for the morning session, April 24. Dr. Overholser was host at a buffet supper for members and guests on Friday evening. The two-day meeting closed with a dinner-dance at the Washington Hotel.

New Officers of the Society were elected at the business meeting on Saturday. They are:

Dr. Jay L. Hoffman, *President*; Dr. Joseph Abrahams, *Vice President*; Dr. David W. Harris, *Secretary-Treasurer*; Drs. Norman Taub and William L. Granatir, *members of Executive Committee.*

The 52nd Annual Meeting of the D. C. Tuberculosis Association was a dinner meeting, May 10, at the National Press Club. The guest speaker was Dr. Jerome R. Head, Associate Professor of Surgery, Northwestern University, who is also Chief Thoracic Surgeon of Hines VA Hospital in Chicago. He spoke on "Golden Anniversary Appraisal of Voluntary Tuberculosis Movement."

Dr. R. Lomax Wells, President of the Association, presided and gave his annual report.

Elected to the Board of Directors for a three-year term were Drs. Frank S. Ashburn and Margaret M. Nicholson, and for a two-year term, Dr. I. Phillips Frohman. Physicians reëlected for a term of three years were Dr. Wells and Dr. Howard M. Payne.

Dr. R. Lomax Wells was reëlected President of the Association at the meeting of the Board, May 12.

The Sixth Annual Meeting of Participating Physicians of Medical Service of the District of Columbia was held in the Medical Society's Building, April 28. The reports of the President, Administrator, and Chairman of Physicians' Services, which were presented at this meeting, are published in this issue of the MEDICAL ANNALS.

Four additional members were elected to the Board of Trustees at this meeting, increasing the total number from 11 to 15. Dr. John E. Alexander was elected to represent a coalition of Arlington, Fairfax and Alexandria City Medical Societies; Dr. William B. Hagan, to represent a coalition of Montgomery County and Prince Georges County Medical Societies; Robert C. McCann, Vice President of Chesapeake and Potomac Telephone Companies, and Robert M. Holmes, Jr., Employee Relations Officer of the Library of Congress, to represent the lay public.

Dr. Edgar McPeak is a new member of the Board, nominated by the Medical Society, who also renominated Dr. Frank D. Costenbader and Dr. Henry L. Darner. Reëlected, in addition to Drs. Costenbader and Darner, were Dr. Daniel L. Seckinger, Dr. G. Halsey Hunt, Bruce Baird, and Philip M. Talbott. Dr. Hunt is Assistant Surgeon General of Public Health Service.

Continuing to serve on the Board are Drs. Donald Stubbs, William P. Herbst, James A. Dusbabek, Arch L. Riddick, and Theodore Wiprud, *ex officio* member.

The Board of Trustees met for its annual meeting and election of officers at the Washington Hotel, May 11. All the officers were reëlected. They are: Dr. Stubbs, *President*; Dr. Herbst, *First Vice President*; Dr. Hunt, *Second Vice President*; Mr. Baird, *Treasurer*; and Mr. Wiprud, *Secretary*.

Members of the Executive Committee are Dr. Stubbs, *Chairman*, Drs. Herbst, Darner, Riddick, Hunt, and Mr. Wiprud, *Secretary ex officio*.

The Section on Neurology and Psychiatry met in the Medical Society's auditorium, May 20. Dr. Elizabeth Roboz read a paper on "Proteins and Lipids in Multiple Sclerosis"; co-authors of the paper were Drs. Walter C. Hess, Francis M. Forster, Tiffany Lawyer, Joseph Provenzano, and Diane Temple. Dr. Walter Freeman gave an illustrated lecture on "Transorbital Lobotomy; Part III: Anxiety." The discussion which followed the presentation of papers was led by Dr. Henry E. Andren.

The new officers for the **Washington Medical and Surgical Society** are:

Dr. Emil J. C. Hildenbrand, *President*; Dr. Karl C. Corley, *Vice President*; Dr. J. Phelps Hand, Jr., *Secretary*; Dr. George W. Reeves, *Treasurer*.

The special series of lectures on cancer detection and treatment for general practitioners, sponsored by the Section on General Practice of the Medical Society of the District of Columbia and the District of Columbia Division of the American Cancer Society, was announced in the April issue of the MEDICAL ANNALS. The last lecture, held on May 13, concerned "Lymphomas and Leukemias" and was given by Lt. N. R. Shulman, MC, USN, of the Department of Hematology, U. S. Naval Medical Research Institute, Bethesda, Md.

Speakers for the first four lectures appeared in the April issue. Topics and speakers at the other sessions were: "Breast Cancer," Dr. Murray M. Copeland; "Cancer of the Rectum," Dr. A. F. Castro; "Lung Cancer," Dr. Arnold M. Salzberg; "Cancer of the Thyroid," Dr. Robert J. Coffey; and "Soft-tissue Tumors," Dr. Richard Brasfield, of Pack Medical Group, New York City.

The Alexandria Medical Society has concluded a special series of **health forums** for the public, which were held weekly in the auditorium of the Mount Vernon School in Alexandria from April 27 through the month of May. A number of civic groups coöperated in the project. Subjects presented were: high blood pressure, arthritis and rheumatism, child health, obesity, and poliomyelitis. Among the speakers were a number of Associate members of the District Medical Society, including Drs. Alvin C. Wyman, William J. Weaver, James B. Gilbert, Arthur J. Mourot, George P. Lemeshewsky, Ben C. Jones, Jr., H. D. Wolff, Jr., and Herman I. Slate. Dr. Christopher J. Murphy, Jr., an Affiliate member of the District Medical Society, was general chairman for the forums.

GENERAL NEWS

At the regular meeting of the **Executive Board of the Medical Society of the District of Columbia,** April 26, the sum of $200 was authorized as financial assistance to Mr. Angelos L. Paraskevas, President of the Junior Class of Georgetown University School of Medicine, and to Mr. Ernest J. Simak, Secretary of the George Washington University Chapter of the Student American Medical Association in order to enable them to attend the annual meeting of the Student AMA in Chicago, May 1, 2 and 3.

Dr. Raymond O. Dart, who is the new Medical Director of the Regional Blood Center of the District of Columbia Chapter of the American Red Cross, was approved as ex officio member and Secretary of the Society's Committee on Blood. This committee is engaged in setting up a Committee on Blood Program in the District of Columbia Chapter of the American Red Cross and had nominated one of its members, Dr. Frank W. Konzelmann, to this committee. The Executive Board confirmed this appointment.

Dr. Edward L. Rea, Medical Officer of the Alcoholic Ward, D. C. General Hospital, recently elected to Active membership in the Society, was appointed to the Subcommittee on Alcoholism of the Committee on Public Health.

The Board moved that the present delegates to United Community Services of Washington, Drs. Wallace M. Yater and Josephine Renshaw, be reappointed.

The District of Columbia Division of the American Cancer Society has approved a $500 grant to the D. C. Medical Society from 1954–55 funds to be used for speakers on cancer subjects at the First Interstate Scientific Assembly, to be held at the Shoreham Hotel, November 1, 2 and 3.

Camp doctors are needed for Camp Ernest W. Brown, a vacation retreat for underprivileged boys sponsored by the Metropolitan Police Boys' Club; it is located near Point Lookout, Maryland, in pleasant surroundings. The camp will be open for 9 weeks beginning June 25. Medical students who have at least completed their sophomore year may apply by calling Dr. Everett J. Gordon, National 8-1514.

Dr. Alan D. Miller, Director of the Prince Georges County Mental Health Clinic, advises the Medical Society's Executive Offices that the name of the clinic has been changed to **Mental Health Study Center.** "The new name," he says, "more accurately reflects the scope of our activities, which are both research and clinical. In addition, it is more descriptive of our administrative position in the community. The change is one in name only and, of course, has no bearing on our activities."

Attention is directed to the **List of National and Regional Meetings scheduled for Washington, D. C.,** which is appearing each month in the Advertising Section of the Medical Annals. This list is being published for the convenience of physicians who wish to schedule their appointments so as to take advantage of their residence in the National Capital, a meeting place for an increasing number of national and international medical conventions.

PERSONALS

Rear Admiral Bartholomew W. Hogan succeeds Rear Admiral Clarence J. Brown as Deputy and Assistant Chief of the Bureau of Medicine and Surgery, effective May 1.

Admiral Brown has served in the position since January 29, 1951, and has been placed on the retired list of officers of the Navy as Vice Admiral.

Admiral Hogan comes to the Navy Department from an assignment as Pacific Fleet Surgeon on the staff of the Commander-in-chief, U. S. Pacific Fleet. He is a veteran of over 28 years' Naval service and attained the rank of Rear Admiral as of April 1, 1952. He is a former Commanding Officer of the Naval Medical School and the Naval Hospital in Bethesda, Md.

During World War II Admiral Hogan served as Senior Medical Officer on the *U.S.S. Wasp.* He was aboard that carrier when she was torpedoed by a

Japanese submarine on September 15, 1942. He was decorated for heroic service during this action and for outstanding heroism on the same day after the personnel of the Wasp had been rescued by the crew of the *U.S.S. Duncan.*

Admiral Hogan is Associate Professor of Psychiatry at Georgetown University School of Medicine. He is a member of the American Medical Association, the American College of Physicians, and the American Psychiatric Association; a diplomate of the American Board of Psychiatry and Neurology; and a member of the Executive Council of the Association of Military Surgeons of the United States.

Dr. Louis K. Alpert, of Washington, has been appointed Chairman of the Committee on Detection and Education of the American Diabetes Association for 1954, succeeding Dr. John A. Reed, who has held the chairmanship of the national Diabetes Detection Drive for the past 5 years. **Diabetes Week** will be observed this year from November 14 to 20.

Dr. Alpert, an Active member of the District Medical Society, is Chairman of the Committee on Affiliate Associations of the ADA. He is Adjunct Clinical Professor of Medicine at George Washington University School of Medicine.

The national offices of the American Diabetes Association are now located at 1 East 45th Street, New York 17, N. Y.

Dr. William J. Tobin, Associate Professor of Orthopedic Surgery, Georgetown University School of Medicine, presented a paper entitled, "The Internal Architecture of the Femur from the Clinical Viewpoint," April 24, at the meeting of the Sixth Surgical Service of the Boston City Hospital in Boston, Mass.

On April 16 and 17, Dr. Tobin participated in Part I examinations of the American Board of Orthopaedic Surgery, which were held at the University of Virginia in Charlottesville.

Dr. James W. Watts, Professor of Neurological Surgery at George Washington University School of Medicine, attended the Ninth Annual Congress of the International College of Surgeons in Sao Paulo, Brazil, April 26 to May 2, as a voting delegate, representing the United States Section of the College. Dr. Watts, who is Chairman of the College's Section on Neurosurgery, addressed the meeting on the subject, "Working Ability Following Prefrontal Lobotomy."

Dr. Jonathan M. Williams spent the first two weeks of April in the Dominican Republic, where he had been invited to lecture before various doctors' groups and medical students, to see some patients in consultation, and to perform some operations. His lectures dealt with neurology and neurosurgery.

Dr. and Mrs. Williams made the trip by plane, accompanied by their son, Stephen. They stopped off in Haiti, where Dr. Williams made an unofficial inspection of medical facilities. The party returned to Washington on April 19.

Dr. Edward J. Stieglitz addressed the Industrial Health Conference at the Hotel Sherman in Chicago, April 27, on "Constructive Health—Management's Stake in Industrial Health Programs."

Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, was recently appointed Chairman of the Medical Advisory Board of the American Legion. Dr. Overholser has been a member of the Board since it was established in 1944.

Dr. Edward L. Rea, Medical Officer of the Alcoholic Ward, District of Columbia General Hospital, addressed the Public Health Committee of the Washington Board of Trade at a luncheon meeting in the Burlington Hotel, April 29. Captain John Layton, formerly in charge of the Narcotic Squad, was another guest speaker. Dr. Oscar B. Hunter, Jr., presided in place of Dr. J. Ross Veal, Chairman of the Committee, who was out of town.

Lt. Colonel Lorenz E. Zimmerman, MC, USA, was a guest speaker at the April meeting of the Helminthologic Society of Washington, which was held at the Georgetown University School of Medicine. He spoke on "Epidemic Hemorrhagic Fever." He lectured on the same subject at a weekly meeting of the 354th General Hospital, April 22. Colonel Zimmerman is an Associate member of the District Medical Society.

Dr. Harold Stevens presented a paper on "Puerperal Hemiplegia" before the Annual Meeting of the

American Academy of Neurology, which opened at the Shoreham Hotel, April 26. **Dr. Francis Forster,** Vice President of the Academy and Dean of the School of Medicine of Georgetown University, was Chairman of the Program Committee.

Drs. I. Phillips Frohman, Emil J. C. Hildenbrand and J. Rogers Young participated in the first Safety Program for Construction Supervisors, sponsored by the Master Builders Association, which is the D. C. Chapter of the Associated General Contractors of America, Inc.

Approximately 200 construction supervisors attended the first meeting, May 4, when Dr. Frohman spoke. Dr. Hildenbrand addressed the supervisors, May 11 and Dr. Young, May 18. The meetings were held in the St. John's College Auditorium on Vermont Avenue.

Dr. Bernard J. Walsh was elected to the Board of Directors of the American Heart Association for a three-year term, 1954–56, at the meeting of the Board in Chicago early in April. Dr. Walsh is Past President of the Washington Heart Association and Associate Clinical Professor of Medicine at Georgetown University School of Medicine.

Dr. V. L. Ellicott, of Bethesda, Md., has resigned as Health Officer for Montgomery County, Maryland after serving in that post for 22 years. He has accepted an advisory position with the chronic disease program of the Maryland Department of Health and will retain his present title as Deputy Health Officer with the state department.

Dr. Ellicott received his medical degree and Doctor of Public Health degree from Johns Hopkins University. Prior to coming to Montgomery County in April 1932 he served for two years as an epidemiologist with the New York State Health Department and for 10 years as epidemiologist with the Baltimore City Health Department. He has been an Associate member of the District Medical Society for many years, having just resigned upon moving to Baltimore.

The County Health Department has seen phenomenal growth during Dr. Ellicott's incumbency. From a staff of 4, the department now has personnel of 83; his annual budget, $11,000 in 1932, is about $500,000 for 1954. From a small suite in the old courthouse in Rockville, the Health Department is now housed in a modern health center attached to the new County Office Building.

Dr. Waldo B. Moyers, Hyattsville, was elected a Vice President of the Maryland Medical and Chirurgical Faculty by the House of Delegates at the 156th Annual Meeting of the Faculty in Baltimore, April 29. **Dr. Thomas A. Christensen,** College Park, was elected Councilor. Both physicians are Associate members of the District Medical Society.

Dr. George William Ware has recently been certified by the American Board of Thoracic Surgery.

Dr. Allan E. King received the silver Vicennial Medal of Georgetown University, May 1, at a Vicennian Medal Mass in the Dahlgren Chapel. The medals are given for 20 years of service to the University, gold for full-time service and silver for part-time service. Dr. King is Clinical Instructor of Obstetrics and Gynecology in the School of Medicine.

Drs. Allan Cross and Alan F. Kreglow were honored for their devotion to civic activities by the Eastern High School Alumni Association, at a dinner meeting, May 5.

Colonel Dwight M. Kuhns, MC, USA, Chief Pathology and Allied Sciences Consultant in the Office of the Surgeon General, was away from Washington during the month of May on a 30-day inspection and lecture tour of laboratory facilities in the Sixth Army area and the Far East. Much of his time at the installations was taken up with lectures on the Army-wide "Cancer Education Program" for the benefit of both Army and civilian personnel. Colonel Kuhns is an Associate member of the District Medical Society.

Dr. Oscar B. Hunter, Jr., retiring President of the Georgetown University Alumni Association, was elected a member of the Board of Directors at the recent annual business meeting.

Dr. W. Ross Morris, President-elect of the Medical Society of the District of Columbia, attended the Sectional Meeting of the American College of Surgeons in London, May 17–19, and is touring the

Continent with Mrs. Morris. Dr. and Mrs. Morris left New York, May 12, on the *H.M.S. Queen Elizabeth* and will return on the *U.S.S. United States*. Some of the countries they planned to visit were Switzerland, Germany, France and Italy.

Dr. and Mrs. A. J. Mourot of Alexandria, Va., left by plane, May 6, en route to London via Dublin, Ireland. Dr. Mourot was in London for the Sectional Meeting of the American College of Surgeons and in Paris for the meeting of the International College of Surgeons. He visited clinics in Dublin, Edinburgh and Rome. The Mourots also toured Switzerland and other places of interest in Italy and Scotland. They returned on the *U.S.S. Independence* from Naples, June 5. Dr. Mourot is an Associate member of the District Medical Society.

Lieutenant Mor James McCarthy, MC, USNR, returned to Washington in March and is presently on the surgical staff of the U. S. Naval Hospital in Bethesda, Md. Dr. McCarthy left the States in December 1952 for Korea, where he served as medical officer with the First Marine Division.

Dr. Carl Henning is transferring his membership to the Sussex County (Delaware) Medical Society. His address is 84 Rehoboth Avenue, Rehoboth Beach, Delaware.

Dr. Joseph M. O'Neill, whose office has been located at 1801 K Street, N. W., moved to California in May. He is on the staff of the Kaiser Permanente Clinic in Los Angeles as obstetrician and gynecologist.

Dr. Herbert Wanderman, who was associated with the Fogel Clinic until October 1, 1953, is reestablishing his practice in Nassau County, New York, and building a new home and office.

On December 1, 1953, **Dr. William D. Chase** joined the medical staff of the Genesee County Tuberculosis Sanatorium in Flint, Michigan.

After four years of general practice in McLean, Virginia, from 1938 to 1942, Dr. Chase served two tours of extended active duty with U.S. Army and 4½ years on the staff of the Veterans Administration Hospital in Reno, Nevada. Until his recent resignation, Dr. Chase had been affiliated with the District Medical Society as an Associate member since 1940.

Dr. William B. Ober, Associate member of the District Medical Society, moved to Boston, July 1, 1953, where he is pathologist at the Boston Lying-in Hospital and Instructor in Pathology at the Harvard Medical School.

Dr. Lorman L. Hoopes, who moved to North Dakota in July 1953, is engaged in the private practice of obstetrics and gynecology. His address is 304 Fourth Avenue, S.E., Minot. He is now a member of his local medical society, the Northwest Medical.

BOOK REVIEWS

Mechanisms of Urologic Disease. David M. Davis, M.D., Professor of Urology Emeritus, Jefferson Medical College; Visiting Lecturer in Urology, Graduate School of Medicine, University of Pennsylvania; formerly Pathologist and Director of Research, James Buchanan Brady Urological Institute, Johns Hopkins University; Assistant Professor of Urological Surgery, in charge of Urology, University of Rochester; Nathan Lewis Hatfield Professor of Urology, Jefferson Medical College. Price, $4.50. Pp. 156. Philadelphia: Saunders, 1953.

In his 140-page book, "Mechanisms of Urologic Disease," Dr. Davis has succeeded in presenting the subject of urology in a new concept which relies on a basis of physiologic rather than anatomic classification. It is brief but concise, and every word is significant to the basic understanding of disease of the urological system.

The book is divided into 13 short chapters dealing with Obstruction, Infection, Stone Formation, Foreign Bodies, Neoplasms, Congenital Anomalies, Trauma, Neurogenic Changes, Infertility in the Male, Lesions of the Scrotal Contents, and Proliferative and Ulcerative Lesions of the Genitalia. There is also a chapter on Catheterization, and one on an Outline for History Taking and Physical Examination. At the end of the book is a list of recommended books of reference.

With the exception of the chapter on neoplasms, which deals with the tumor growths of specific organs, each topic is considered in relation to the genitourinary tract as a whole, rather than to each organ. Detailed descriptions of specific therapy are omitted, but the reader is left with a clear understanding of the methods of treatment to be followed in each type of disorder.

Each chapter contains a list of references to the recent literature on the subject discussed.

This little book should be of utmost value in the teaching of the fundamentals of urology to the medical student, and as an adjunct to the reading of the intern. It can be read and re-read in a matter of a few hours. In a few words Dr. Davis clearly describes the physiology of the formation and conduction of urine, and in subsequent paragraphs shows how this basic fundamental knowledge is the key to the understanding of much of urinary tract disorder.

The chapters on the urological history and physical examination give an excellent outline. The chapter on catheterization serves a most useful function in bringing to the attention of the student an often neglected and important subject.

"Mechanisms of Urologic Disease" is a most useful and practical addition to the armamentarium for the teaching of urology.

MARSHALL U. RUMBAUGH, M.D.

The Psychiatrist: His Training and Development. Report of the 1952 Conference on Psychiatric Education held at Cornell University, Ithaca, New York, June 19–25, 1952. Organized and conducted by the American Psychiatric Association and the Association of American Medical Colleges. Editoral Board: JOHN C. WHITEHORN, M.D., *Chairman*; FRANCIS J. BRACELAND, M.D., VERNON W. LIPPARD, M.D., AND WILLIAM MALAMUD, M.D. Price, $2.50. Pp. 214. Washington, D. C.: American Psychiatric Association, 1953.

It will greatly surprise the average medical reader to learn of the vast amount of effort, time, and expense that goes into the making of the present-day psychiatrist. Not too many years ago, the embryo psychiatrist was tossed into the arena of the large state hospital to wrestle as best he could with his patients' problems, the cynicism of his colleagues, and his own disturbing anxieties. All this has changed radically in the past 25 years and especially in the last 10 years. Many factors have been responsible for this change, but most important have been the psychoanalytic movement, the development of the American Board of Psychiatry and Neurology, the discovery of more effective treatment methods, and the emergence of psychiatry after World War II as a valued and respected specialty.

Most conference reports are of greatest interest to those who attended the conference, but usually prove to be rather dull going to those who did not. This book is a happy exception. Due to the brilliant and ruthless editing by Dr. Whitehorn and his colleagues, this report forms a lucid, compact and beautifully written account of modern psychiatric training. Here one can find in distilled form the best thinking of the leaders of American psychiatry, their points of general agreement, their disagreements, and the many problems still to be solved. For example, in the chapter on Psychodynamics, which is defined as "the systematized knowledge and theory of human behavior and its motivation," both analytic and nonanalytic views are presented in such a way as to be more illuminating than confusing, even when there is direct conflict.

A matter which will be of considerable interest to psychiatrists and nonpsychiatrists alike is the set of conclusions reached by the Conference in regard to the role of psychoanalysis in residency training. The conclusions are as follows:

"1. It is not necessary to be psychoanalyzed in order to develop competence as a psychiatrist, including competence in psychotherapy and psychodynamics.

2. It is highly desirable that some persons should receive a personal psychoanalysis and psychoanalytic training because of the contributions which psychoanalysis may make in varying degrees to the personal adjustment of the psychiatrist, to his skills as a therapist, and to his understanding of the basic science of psychodynamics. For those who are to practice the specialty of psychoanalytic therapy, such psychoanalytic training is considered a necessity.

3. For those who decide to get psychoanalytic training to become psychoanalysts, or who for other reasons undertake personal psychoanalysis, there is a problem of when to do so—whether it should be done during the residency training, before it, or following its completion. It is recognized that this problem cannot be solved in general terms for all persons, institutions, and situations, but must be met according to the specific needs and circumstances."

There are excellent chapters on the various training centers, details of the "ideal" and actual training programs and the role of child psychiatry in residency training. The special fields such as forensic psychiatry, administrative psychiatry, and military psychiatry are most competently handled.

This book can be highly recommended as an authoritative source book for any physician who wishes to specialize in psychiatry or any of its branches. It also provides an excellent method for the interested physician to learn just what is going on and what should be going on in psychiatry. The American Psychiatric Association, Dr. Whitehorn, and all others connected with this venture should be commended for publishing such a useful volume.

ZIGMOND M. LEBENSOHN, M.D.

ALVIN RANDOLPH SWEENEY, B.S., M.D., F.A.C.P.

(1881–1954)

Dr. Alvin R. Sweeney, who was Superintendent of Gallinger (now District of Columbia General) Hospital from 1945 until he resigned because of ill health in 1949, died, April 17, 1954, at the U. S. Marine Hospital in Baltimore of a heart ailment. He lived at 5126 Bradley Boulevard, Chevy Chase, Md.

Dr. Sweeney was born in Grand Chenier, Louisiana, September 2, 1881, son of the late Dr. and Mrs. George C. Sweeney. He received his early education in the public schools of Cameron Parish, La., and Acadia College, Lake Charles, La.

He received his B.S. degree from Texas Central University, Greenville, Texas. He was enrolled in Vanderbilt University School of Medicine from 1904 to 1907 and graduated in medicine from Jefferson Medical College in 1908. After engaging in private practice at Lake Arthur, La., until February 1913, he accepted a commission in the United States Public Health Service as Assistant Surgeon, and continued in the Regular Service for almost 33 years.

His first assignment in the Service was at Ellis Island Immigration Station, New York. Thereafter he served at the New Orleans and Galveston Quarantine Stations, and at the U. S. Marine Hospital in St. Louis until the entry of the United States in World War I, when he assumed command of that installation. During the war he was in charge of public health programs relating to cantonment areas in the South.

Following World War I he was in charge of the Marine Hospital in St. Louis and later, Chief of the Quarantine Station of the Port of Boston, Mass. For his humanitarian services he was elected to life membership in the Boston Chamber of Commerce. He was Commanding Officer of the Marine Hospitals in Ellis Island and Cleveland and Medical Officer for the Ninth Naval District before he retired from the Service in 1945. He became Superintendent of Gallinger Hospital the same year. While at Gallinger he worked to improve the Psychiatric Department and reorganized the Hospital's auditing system.

He had lectured at Harvard School of Public Health and had written articles relating to the field of public health.

He spoke 10 languages. He was a student of poetry, philosophy, music, and art. Since his retirement he had spent much time in California, where he took up painting. One of his oil landscapes hangs in the District Hospital.

Dr. Sweeney became affiliated with the Medical Society of the District of Columbia as an Active member in 1946 and retained his membership until his death. He was a Fellow of the American College of Physicians, and a member of the Americian Medical Association, the Association of Military Surgeons of the United States, the American Public Health Association, the American Academy of Political and Social Sciences, and the Washington Health Council. He was a 32nd degree Mason and a member of the Washington Board of Trade.

Surviving are his wife, Mrs. Adele Ingram Sweeney; two sons, Dr. A. Randolph Sweeney, Jr., of Los Angeles, Calif., and Edward C. Sweeney, Wallingford, Pa.; and two daughters, Mrs. Clark E. Brown and Miss Ruth I. Sweeney, both of Washington.

Membership

(*Continued from page 352*)

Recent changes in membership status:

Reinstated to Active

Catherine W. Johnson
Laszlo N. Tauber

Reinstated to Associate

Ralston H. Adams
Lester J. Dugan

Active to Associate

Peter P. Andrews
Clifford E. Bagley
David F. Bell, Jr.
Rex E. Buxton
L. Huntley Cate
John P. Haberlin
Joseph N. Hamm
Paul Kaufman
James L. Kelley, Jr.
William F. Kellow
Joseph C. McCarthy
James M. Moss
Hewitt I. Varney
Ferdinand Welebir
Stanley I. Wolf

Active to Affiliate

Michael L. Buckley
Ralph J. Carbo, Jr.
Russell B. Diley

Active to Resident-Intern

Charles W. Humphreys, Jr.

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THE DISCREPANCY BETWEEN HOME AND OFFICE RECORDINGS OF BLOOD PRESSURE IN PATIENTS UNDER TREATMENT WITH PENTAPYRROLIDINIUM. IMPORTANCE OF HOME RECORDINGS IN ADJUSTING DOSAGES*

EDWARD D. FREIS, M.D.
Clinical Adjunct Professor of Medicine, Georgetown University School of Medicine

EARLY in the course of investigations on antihypertensive drugs it became evident that many if not the majority of patients who exhibited favorable responses to certain agents while in the hospital appeared to lose this reactivity after they left the hospital. With the advent of the ganglionic-blocking agents it became necessary to follow the blood pressures more closely than could be accomplished with occasional visits to the office or clinic. As a result, certain patients were taught to record their blood pressures in the home or while at work. It soon became evident that in many instances there often was a striking difference between the level of blood pressure as recorded in the home and as recorded in the office. It was found that the majority of the patients did not lose their responsiveness to the medication after discharge from the hospital. Rather, the visit to the doctor was a pressor stimulus of such magnitude that the hypotensive effects of the drug frequently were overcome.

This observation seemed to have obvious clinical importance, since, if the physician depends only upon office recordings of blood pressure in such cases, he will be unable to recognize the point at which a therapeutic dose level has been obtained. The development of pentapyrrolidinium (Ansolysen, M&B 2050) has given the doctor an oral antihypertensive agent which is effective even in the severe cases of hypertension.[1, 2] But, because of its potency and the

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* From the Cardiovascular Research Laboratory, Georgetown University Hospital, and the Veterans Administration Hospital, Washington, D. C.

This study has been supported in part by Research Grant H-720, National Heart Institute, U. S. Public Health Service; The Squibb Institute for Medical Research, New Brunswick, New Jersey; and Irwin, Neisler and Company, Decatur, Illinois.

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variability of dosage requirements from one patient to another, it is vital that the physician have an accurate record of the extent of blood pressure reduction. If his readings are misleadingly high, he may unwittingly increase the dosage beyond the therapeutic range and thus precipitate severe side-effects. The purpose of the present study is to document observations on home versus office or clinic blood pressures in patients receiving pentapyrrolidinium.

MATERIALS AND METHODS

A sample of 32 patients was selected who received a period of hospitalization for at least 1 week prior to the institution of therapy. The blood pressure was recorded 4 to 6 times daily by the nursing staff. The blood pressure values recorded during the last 2 days of pre-treatment observation were averaged, and this value was used as the pre-treatment level of blood pressure. Only patients whose average blood pressure was 180/110 or higher at the end of the observation period were treated with pentapyrrolidinium.

Twenty-three of the patients were males and 9 were females. According to the Keith, Wagener and Barker classification,[3] 2 of the patients exhibited Grade I, 11 Grade II, 5 Grade III, and 14 Grade IV changes in the optic fundi. No effort has been made to select the patients who later showed the greatest discrepancy between home and office blood pressure readings.

In each case the patient or a member of the family was taught to record the blood pressure, and such readings were taken 2 to 4 times daily after discharge from the hospital. The blood pressure values recorded with the patient in the sitting position were averaged to obtain the mean of the home readings. The office or clinic pressures were taken under the following circumstances: The patient and the physician were alone in a quiet room. Following a report by the patient of his symptoms and side-effects, if any, the blood pressure was recorded 5 times with the patient in the sitting position using the standard auscultatory method. The patient then was asked to stand, and the blood pressure was recorded twice in the erect position. The lowest of the 5 pressures recorded in the sitting position during each visit was used in computing the average of the office readings.

Although the average period of treatment in this group of patients has been 9 months, only the data obtained during the first 3 months of treatment were used in the present study. The reasons for this are twofold: First, the early months represented the period of adjustment of dosage when accurate blood pressure was of greatest importance in regulating dosages, and second, in some of the patients, after a number of months had passed, the office recordings began to approach more closely the home recordings.

In each instance, when a discrepancy was found between office and home recordings, the patient or another individual who took the blood pressure at home was asked to repeat his readings in the office immediately after the physician finished his recording. In only 1 instance was the technic of home recordings found to be inaccurate, and this case was not used in the present series.

RESULTS

In regard to systolic blood pressure, the average of the home post-treatment recordings was 30 mm. Hg or more lower than the pre-treatment hospital readings in 31 of the 32 cases (table 1). In 22 or 68 per cent the average home reading was 50 mm. Hg or more lower than the pre-treatment reading, and in almost half of the cases the mean systolic pressure was 70 mm. Hg or more lower than the pre-treatment values. Thus, on the basis of home recordings, all except 1 case exhibited a significant reduction of systolic pressure.

When the blood pressures recorded in the office or clinic following discharge of the patient from the hospital are used as the standard for judging therapeutic results, 12 patients, or 37 per cent of the group, showed less than 20 mm. Hg reduction of pressure, and 22 or 68 per cent less than 30 mm. Hg reduction. Thus, on the basis of office or clinic readings, 68 per cent of patients failed to maintain a significant reduction of systolic blood pressure following discharge from the hospital.

TABLE 1

Difference between Home and Office or Clinic Post-treatment Recordings of Blood Pressure as Compared to Pre-treatment Hospital Blood Pressure in 32 Patients under Treatment with Pentapyrrolidinium

TYPE OF COMPARISON	NO. OF CASES	PER CENT OF TOTAL
Systolic Pressure		
Post-treatment home compared to pre-treatment hospital blood pressure		
Home pressures less than 30 mm. Hg lower.	1	3
Home pressures 30 mm. Hg or more lower	31	97
Home pressures 50 mm. Hg or more lower	22	68
Home pressures 70 mm. Hg or more lower	15	47
Post-treatment office or clinic compared to pre-treatment hospital blood pressure		
Office pressures less than 20 mm. Hg lower	12	37
Office pressures 30 mm. Hg or less lower	22	68
Office pressures 40 mm. Hg or less lower	28	88
Diastolic Pressure		
Post-treatment home compared to pre-treatment hospital blood pressure		
Home pressures less than 20 mm. Hg lower	5	16
Home pressures 20 mm. Hg or more lower	27	84
Home pressures 30 mm. Hg or more lower	18	56
Home pressures 40 mm. Hg or more lower	8	25
Post-treatment office compared to pre-treatment hospital blood pressure		
Office pressures less than 10 mm. Hg lower	13	41
Office pressures 20 mm. Hg or less lower	26	81

In regard to diastolic blood pressure, the average post-treatment home recording was 20 mm. Hg or more lower than the mean pre-treatment reading in 27, or 84 per cent, of the cases, whereas the average follow-up office recording was 20 mm. Hg or more lower than the pre-treatment reading in only 6, or 19 per cent, of the patients. On the basis of home recordings more than half of the patients exhibited reductions of diastolic pressure of 30 mm. Hg or more (table 1).

Discussion

It may be disputed that the home recordings of blood pressure do not represent the therapeutic effect of the drug but rather the expected difference between home and office blood pressure levels regardless of whether the patient was under treatment or not. This argument is somewhat beside the point, since the aim of the treatment was to maintain the average level of blood pressure in a range which the therapist considered to be satisfactory. In the majority of patients the home recordings indicated that this was the case, while the office recordings did not.

Another interpretation of the above data is that the home recordings more accurately reflected the therapeutic effects of the drug, whereas the office recordings represented an "escape" from the hypotensive effect of the drug occasioned by the apprehension associated with the visit to the doctor's office or clinic. There is much collateral evidence to support this interpretation. First, the cases in this series were selected on the basis of being so-called "fixed" types of hypertensive patients. They failed to show reductions of blood pressure below 180/110 mm. Hg after being hospitalized for 1 week or longer. Second, the administration of therapeutic doses of pentapyrrolidinium was associated with a significant reduction of blood pressure while the patient was in the hospital, and this level was maintained in the home recordings following discharge from the hospital. Third, home recordings, particularly in the first month of treatment, disclosed varying degrees of postural hypotension which undoubtedly were drug-induced. Fourth, home recordings often disclosed dips of blood pressure to the normal range even in the patients with malignant hypertension. Fifth, it frequently was necessary to decrease the patient's dosage, because home pressures disclosed periods of low blood pressure associated with symptoms of weakness and faintness which disappeared when the dosage was reduced. Sixth, in the patients with malignant hypertension obvious objective improvement, such as disappearance of papilledema and clearing of hemorrhages and exudates in the optic fundi, continued after discharge from the hospital, and in the cardiac patients the degree of heart failure was markedly reduced or cleared completely as compared to the pre-treatment state. In brief, symptoms, side-effects and objective improvement correlated in a credible and rational way with the home recordings of blood pressure, whereas there was no, or very poor correlation of these collateral observations with the office blood pressure values in many instances.

That certain emotional stimuli counteract the hypotensive effects of the ganglionic-blocking agents has been documented by Smirk.[4] He showed that when these drugs are given by continuous intravenous infusion it is possible to reduce the blood pressure to a selected level and maintain this under quiet conditions with little alteration. However, conversations with the patient involving emotional topics still raised the blood pressure considerably. This observation has repeatedly been corroborated in this clinic under hospital control conditions. It has been shown both in animals[5] and in man[6] that the ganglionic-blocking agents potentiate the pressor effects of circulating epinephrine and norepinephrine. Whether epinephrine release or some other mechanism is responsible is unknown, but there seems to be ample evidence that the patient can escape from the hypotensive effects of the ganglionic-blocking agents under psychic stress.

Other investigators who have had extensive experience with the ganglionic-blocking drugs in treating hypertensive patients also emphasize the importance of utilizing some other method than doctor's office recordings of blood pressure in regulating dosages. For example, Smirk[7] states, "Casual blood pressures are taken, but they are of very little use in the control of dosage. Quite high blood pressures may be encountered in outpatients whose blood pressure is satisfactory under home conditions." Schroeder,[8] in discussing the control of patients out of the hospital, states, "The patient (or a member of the family) is instructed in the use of the sphygmomanometer, and measures his own blood pressure before each dose, checking the readings frequently with an experienced observer."

The objection frequently is raised that by recording blood pressure in the home undue emphasis is placed on blood pressure per se, and so may fix a neurotic obsession. Those who claim this have made few or no personal observations of the effects of home pressure recordings. Their opinion has been a reasonable assumption rather than a verified scientific fact. By the same reasoning one might expect that diabetic patients would develop neurotic fixations concerning their disease, since they record their urine sugar concentrations at home several times daily. Most physicians would agree that if this method of managing diabetes induces a neurotic obsession it is not necessarily harmful to the patient.

Many so-called "problem" cases of hypertension are referred to this clinic. Frequently the patient is a middle-aged woman referred because of extremely high levels of blood pressure. Examination, however, discloses little or no organic damage. Such patients usually are extremely apprehensive about their blood pressures, and, even in those cases in which the readings have been hidden from the patient, questioning often reveals that the patient is aware of the fact that her office levels are dangerously high. Unless the patient is already neurotic, such problems have been solved satisfactorily by lending the patient a manometer for a short period in order to obtain a record of the home pressures. In most instances the home recordings are found to be normal or nearly so, or, if not, will respond readily to hypotensive medication. In our experience, therefore, if we are not dealing with a basically unstable or neurotic personality, home recordings provide greater reassurance than any other therapeutic procedure. That which was mysterious and threatening to the patient becomes straightforward and matter-of-fact.

It is not to be implied that all patients with hypertension require home blood pressure recording. The apparatus is expensive and the procedure time-consuming. More important, many cases of hypertension are benign, and there is no need to focus the patient's attention so frequently on his disorder. However, in the problem cases and in the patients under treatment with the ganglionic-blocking drugs, such as pentapyrrolidinium, home recordings have been of great value, and did not seem to produce an unhealthy mental reaction in our patients.

It is important to know whether the ganglionic-blocking agents protect the patients at all times or only when they are at rest in the home or hospital. Approximately one third of the present series obtained occasional readings while at work, and in no instance were the readings higher than those obtained at home. Moderate physical exercise also was without effect, and heavy physical work while under treatment with pentapyrrolidinium was more apt to reduce rather than raise the blood pressure. Emotional situations associated with anxiety and apprehension, whether at home or at work, seemed to be the principal pressor stimuli. The patient who records his own pressure quickly learns to recognize and avoid the situations which will raise his blood pressure.

Finally, home recordings of blood pressure have done much to insure the patient's coöperation in the treatment regimen. There is a human tendency to "forget" to take dosages and to modify the physician's instructions. When these lapses occur the patient finds the results of his indiscretion reflected in a rise of blood pressure. He also learns to recognize the side-effects associated with hypotension and the need for modifying dosage. He can supply the physician with precise information as to the relation of side-effects and blood pressure readings so that the therapist is not left in doubt as to whether to raise or lower the dosages.

Summary and Conclusions

A series of 32 hypertensive patients were hospitalized and treated with pentapyrrolidinium. During the follow-up period blood pressure recordings were obtained at home as well as in the office or clinic and compared to the pre-treatment hospital control blood pressures.

1. In all except 1 patient the average, post-treatment systolic home pressure was 30 mm. Hg or more lower than the pre-treatment hospital pressure. However, in only 10 patients was the average, systolic office pressure 30 mm. Hg or more lower than the pretreatment, hospital pressure.

2. The average post-treatment, home diastolic pressure was 20 mm. Hg or more lower than the mean pre-treatment, hospital reading in 27 patients, whereas the average, post-treatment office recording was 20 mm. Hg or more lower than the pre-treatment reading in only 6 patients.

3. Evidence is presented to support the conclusion that the excessively high office pressures while under treatment are due to "escape" from the hypotensive effects of the drug during the time the patient visits the office or clinic.

It is concluded that the majority of hypertensive patients under treatment with ganglionic-blocking agents require daily recording of blood pressure in the home during the period of dosage adjustment in order to prevent overdosage and consequent undesirable side-effects.

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(Continued on page 414)

CONGENITAL TUBERCULOSIS*

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CONGENITAL, in Dorland's dictionary,[1] is defined as "born with a person; existing at or before birth." Congenital tuberculosis has been recognized as an entity since 1891 when Schmorl and Birch-Hirschfeld first demonstrated tuberculosis in a fetus.[2, 3] Many cases have since been reported, but not all have been accepted. In many cases the infection occurred after birth, and in others only a tuberculous bacillemia occurred without demonstrable lesions. Whether the latter condition constitutes the entity, as some authors imply, has not been settled.

Beitzke, in 1935, set up the following criteria as proof of congenital tuberculosis.[4, 5]

1. The tuberculous nature of the lesions in the infant must be proved.
2. A primary complex in the fetal liver is proof of the congenital nature of the tuberculous changes, since it can have arisen only from tubercle bacilli in the blood of the umbilical vein.
3. If there is no primary complex in the liver, the infection is congenital only if:
    a. Tuberculous changes are found in the fetus in utero or at birth or a few days after birth.
    b. Extra-uterine infection can be excluded with certainty in a child who lives longer than a few days, the child being immediately separated from the mother and kept in an environment free from tubercle bacilli.

In 1948 Harris et al[4] proposed the following definition of congenital tuberculosis: "tuberculosis in which the infection occurs before birth by way of the blood stream, or by aspiration or ingestion of infected amniotic fluid in utero." As will later be shown, this definition precludes, perhaps rightly, three other possible methods of infection. The authors further proposed that ". . . all cases occurring at birth by the aspiration of infected amniotic fluid or tuberculous material present in the birth canal be classified as 'tuberculosis neonatorum.' " This fine distinction between prepartum and intrapartum infection has not been made by many authors.[5, 6]

INCIDENCE

Since Schmorl and Birch-Hirschfeld demonstrated tuberculosis in the fetus numerous cases were reported, and in 1935 Beitzke analyzed the details of all published cases according to the site of the primary complex. He found 61 cases of congenital tuberculosis with lesions and 40 cases in which tubercle bacilli were found without histologic changes.[5] In 1943 Waissmann reported his observations on 737 pregnant tuberculous women from 1934 to 1942. Eleven children born of these women died of congenital tuberculosis, giving an incidence of 1.46 per cent.[2, 7] Hughesdon, in 1946, analyzed, according to Beitzke's criteria, 35 cases between 1935 and 1945 and found 11 proven cases, 1 of which was a tuberculous bacillemia without histologic lesions. In the same article she reported 4 additional cases.[5] An editorial in the J.A.M.A. of June, 1947 stated that there had been 115 proven cases of congenital tuberculosis reported in the past 75 years.[4] The cases were those in which pathologic lesions were found and those in which only a tuberculous bacillemia occurred.

Up to September, 1950 the total number of proven cases, as stated by Amick et al,[6] was 124. These authors cited the works of Beitzke and Hughesdon, and added to the list 8 cases which the latter author did not include. In addition, they reported 4 more cases which fulfilled Beitzke's criteria. In reviewing some of the American literature up to June, 1952, 2 additional cases were found which were not included in either Hughesdon's or Amick's articles. These 2 cases fulfilling Beitzke's criteria were reported by Robertson and Sullivan[2] and Burgess[8] in 1950.

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Excluding those cases which have probably been reported in the foreign literature*[9, 10] the total number of cases of proven congenital tuberculosis lies between 130 and 141. (In their summations most authors made no mention of Waissmann's 11 cases.) The question remains in my mind whether infants dying with a tuberculous bacillemia only should be considered cases of congenital tuberculosis. The factor of prematurity, present in many of these infants, may well in itself be the prime cause of death.

The fact that tuberculous bacillemias do occur in infants without lesions leads some investigators to ask, "How many infants born of tuberculous women are infected without developing the disease?" Siegel and Singer[11] in 1935 cultured the blood of 15 infants born of tuberculous mothers, and from only 1 infant was a tuberculous growth obtained. This particular child, born prematurely at 7 months and weighing 1,100 grams, died 3 hours after birth. At autopsy there was no gross or microscopic evidence of tuberculosis. In all probability death was due to prematurity rather than tuberculosis. In 1945 Loewenstein[12] stated that he had cultured tubercle bacilli many times from the blood of mothers and umbilical cords of infants and in the majority of cases the infants developed normally without evidence of tuberculosis. This led him to conclude that infants developing a tuberculous bacillemia at birth would probably not develop the disease. It is apparent that the incidence of tuberculous bacillemias in infants who subsequently progress without contacting the disease is not well known.

The two articles cited above reported on blood cultures of infants after birth. Siegel and Singer[11] stated in their article that cases have been reported in which tubercle bacilli have been isolated from fetuses without histologic lesions by the inoculation of fetal tissue into guinea pigs. The lack of pathologic lesions in these cases might be explained if the inoculations had been performed very soon after the invasion of bacilli; lesions, then, would not have had time to develop. Rather than this speculation, however, maternal antibodies passing to the fetus[8] and/or the low oxygen-high carbon dioxide tension in the fetal blood[13] probably suppress the tubercle bacilli sufficiently to prevent pathologic changes. If true that the placentas of tuberculous women are frequently infected, as some authors[11, 12] think, it is probable that tuberculous bacillemia in the fetus occurs often.

PATHOGENESIS

The mode of transmission of tubercle bacilli to the fetus in utero seems to be one of the following, in order of probability:

1. Bacilli may be carried from tuberculous foci located either in the fetal cotyledons or placenta by way of the umbilical vein to the fetus.[3]

2. Infected amniotic fluid may be either aspirated or ingested, or it may infect the fetus by way of the middle ear, nose, or eustachian tube.[3]

3. Sperm destined for fertilization may contain tubercle bacilli.[3]

4. Unfertilized or fertilized ova may be infected because of disease in the mother.[3]

5. The early form of the tubercle bacillus may exist as an ultra virus and thus pass the placental barrier.[14]

The greatest number of fetuses, if not all, have become infected by either the first or second route.[2, 4, 5, 6, 8, 12]

Indeed, the definition of congenital tuberculosis proposed by Harris[4] (*vide supra*) emphasizes, by exclusion of other routes suggested, the overwhelming evidence for the first two. In almost all the cases reported, tuberculous lesions and/or tubercle bacilli have been demonstrated in the placenta, amniotic fluid or material obtained on uterine curettage.[5, 8, 11, 15]

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* Spanish translation not available.

Transmission of tubercle bacilli via germ cells has been accepted by some as possible but not very probable.[3, 8, 16] Even with guinea-pig inoculations with fetal tissue, it is extremely rare to find tuberculosis in the fetus before the fourth or fifth month of gestation.[11] On the other hand, as suggested by Vorwald, the low oxygen-high carbon dioxide tension in fetal blood might possibly supress the bacilli for unknown periods. Experimentally in rabbits, however, germinal transmission has been proven, with tuberculous lesions and tubercle bacilli being demonstrated in very young fetuses.

The existence of the tubercle bacillus in ultra virus form has not been proven, although some think the possibility exists.[14]

Clinical Features and Diagnosis

The diagnosis of congenital tuberculosis is extremely difficult and is usually made at autopsy. In most cases tuberculosis in the mother is far advanced, birth is premature, and there may be atypical or no signs and symptoms of severe illness until just before death.[2, 15] The following list of signs and symptoms, in various combinations, indicates the difficulty encountered in diagnosis.

- Prematurity[2-6, 8, 11, 14, 15]
- General
  - Poor feeding[2, 5, 6, 15]
  - Feeble cry[3, 11]
  - Somnolence[15]
  - Weight loss[2, 6]
  - Irritability[5, 6]
  - Fever[4, 5, 6, 14]
- Respiratory
  - Dyspnea[3, 6, 8, 11, 14]
  - Cyanosis[3, 4, 11, 14]
  - Cough[5]
  - Foreign body[15]
  - Bronchopneumonia[2, 3, 14, 15]
- Gastrointestinal
  - Diarrhea[4, 14, 15]
  - Jaundice[5]
  - Melena[4]
  - Vomiting[15]
  - Hematemesis[5]
  - Distended abdomen[8]
- Epistaxis[2, 5]
- Skin abscesses[4]
- Enlarged cervical nodes[6]
- Palpable spleen and/or liver[6]
- Draining ear[6]

A typical picture of an infant with congenital tuberculosis might be one in which the child is born at about the seventh month of gestation of a tuberculous mother. At or shortly after birth, cyanosis and dyspnea develop. The infant may respond and do well on supportive measures until suddenly there is a rise in temperature accompanied by an intractable diarrhea. Persistent hyperpnea may be prominent. Clinically, a bronchopneumonia would be suspected on finding coarse rales throughout the lungs. Tuberculin tests, PPD no. 1 and no. 2, are negative. The child progressively grows worse and death ensues 23 days after birth. Rather than this representative composite, however, the only sign of ill health until just before death may be epistaxis.

Prior to 1950 tuberculin skin tests seemed to be of little value in diagnosis. Of 15 infants tested, who subsequently were proven to have congenital tuberculosis, only 3 positive results were obtained. The earliest date on which the test became positive was 21 days after birth, and in no instance did this information serve to prevent the infant's death.[2, 5, 15] In September 1950 Amick et al[6] reported 4 cases of congenital tuberculosis, in 3 of which there were repeated tests with no. 1 and no. 2 strengths of PPD. In 2 cases there were positive reactions obtained, 1 infant showing a questionable positive reaction on the fourteenth day after birth. On the basis of their experiences the authors believe that infants born of mothers with miliary tuberculosis should be closely followed with repeated PPD skin tests.

X-ray films, although useful in revealing existing pulmonary infections, have not been diagnostic. Even with a high index of suspicion only the label of "consistent with" could be attached to a film.[2, 6]

Prognosis and Treatment

Up to 1949 the mortality rate from congenital tuberculosis was 100 per cent. Reichle and Wheelock[15] in 1939 stated that death usually occurred between the sixteenth and twentieth day after birth. The average length of extrauterine life in 17 cases reported by Hughesdon,[5] Amick et al,[6] Burgess,[8] and Robertson and Sullivan[2] was 22.6 days, with a range of from 0 to 54 days. Excluded from this collection were 2 cases reported by Hughesdon[5] in which the infants lived 13 and 27.5 months and a case reported by Chiari in which the child lived 2.5 years.[14]

In 1949 Lesne, cited by Amick et al,[6] reported the first case of recovery from congenital tuberculosis. The infant, revealing evidence of tuberculosis at 1 month of age, received a prolonged course of streptomycin and was well, more than a year old, at the time Lesne wrote his article. Two further cases with cures were reported by Amick and his associates.[6] The first infant's therapy was started on the seventy-second day of life. Streptomycin, given in the dosage of 60 mg. intramuscularly every 4 hours was continued for 4 months. Fifty-five days after the onset of therapy X-ray films revealed clearing of a previous miliary process. All subsequent X-ray films were negative, and the baby was discharged at 8¾ months with no evidence of tuberculosis but with mental retardation and absent vestibular function. At the time of writing the baby was 26 months old and had no evidence of tuberculosis. The other conditions remained unchanged.

The second infant in which a cure was achieved presented with a purulent discharge from the right ear and enlarged cervical nodes. The diagnosis was made on the seventy-first day of life by cervical node biopsy and treatment instituted immediately. Streptomycin, 250 mg. intramuscularly every 6 hours, was given for the next 53 days. On this regimen the ear infection cleared and the infant's general condition improved remarkably. At 18 months of age the infant was free of any signs of tuberculosis but was mentally retarded and had severe vestibular damage. At 32 months of age there was no evidence of tuberculosis.

Despite the 3 cures reported, the over-all prognosis of congenital tuberculosis remains poor. Amick et al[6] believe that treatment should be started earlier than was done in their cases. This in turn necessitates early diagnosis, and until that is possible the fatality rate will remain high. Perhaps equally as important is the need for development of a regimen of therapy that will leave no residuals.

Morbid Anatomy

Pathologic lesions produced in congenital tuberculosis do not differ from those found in other types of tuberculosis. Grossly, minute yellowish-white nodules may be found on or in any organ. Involved lymph nodes may be enlarged and contain caseous necrotic material. Necrosis and cavitation may occur in any organ. Microscopically there may or may not be epithelioid and giant cells, depending on the time element involved. Often, myriads of acid-fast bacilli can be demonstrated in the tissues.

Evidently attempting to correlate the pathogenesis and pathologic anatomy, the 4 forms of congenital tuberculosis are said to be the following.[15]

1. More common hepatic
2. Generalized miliary
3. Ingestion
4. Aspiration

These forms, with the exception of the miliary, are categorized by the location of the primary complex, involvement of the liver and draining nodes constituting the hepatic form, bowel-mesenteric node changes, the ingestion type, and lung-mediastinal node pathology constituting the aspiration type. That this scheme is deficient is seen by the case of the infant, reported by Amick et al,[6] who had only a purulent discharge from the right ear with cervical adenopathy.

Burgess,[8] quoting Siegel, states that the organs most often involved, in order of frequency, are the lungs, liver, spleen, gastrointestinal tract, and kidneys. In stillbirths, Burgess states, most of the lesions are in the liver, whereas a child dying of congenital tuberculosis at 1 or 2 months of age will have most lesions in the lungs.

Hughesdon[5] in 1946 analyzed 35 cases from 1935 to 1945 according to Beitzke's criteria and reported the following results:

I. Eleven proven cases of intrauterine or intrapartum tuberculosis
    1. Seven transplacental infections via fetal blood stream
        a. One with primary complex in liver only
        b. Four with primary complexes in liver and lungs
        c. One with miliary tuberculosis and no definite primary complex
        d. One with tuberculous bacillemia and no lesions
    2. Four cases with aspiration of infected amniotic fluid into the lungs
        a. In 1 the primary focus may have been the skin

II. Fifteen cases probably but not definitely proved
    1. Twelve, transplacental spread
    2. One, aspiration of infected amniotic fluid
    3. Two, by ingestion of infected amniotic fluid

III. Nine cases probable

From these recent statistics, it would seem that miliary spread is uncommon. In many cases reported, however, involvement of numerous organs was the rule rather than the exception.[2-6, 8, 14, 16]

SUMMARY

Although infrequent, congenital tuberculosis is not rare. A part of the American literature has been reviewed and the various aspects of this entity discussed through compilation of data in the articles read. The greatest development undoubtedly has been the reports of cures within the past 3 years.

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MEDICAL MANAGEMENT OF BILIARY DISEASE*

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BILIARY tract disease is for the most part a surgical problem. Biliary tract surgery may tax a surgeon's skill and judgment to the utmost. Certainly no one should attempt to do gallbladder surgery who is not competent to deal with problems concerning the hepatic and common ducts. For the most part the medical man's role is to assist in adequate preoperative diagnosis and preparation of the patient and to direct his postoperative care.

The treatment of acute cholecystitis is surgical, and in view of the time I shall say no more about it, except to note that we seem to have better results when cholecystectomy is performed after the acute attack has subsided rather than when it is at its peak. Similarly, when cholelithiasis is the cause of symptoms, surgery is the only effective treatment. However, some patients refuse surgery and others are considered poor operative risks. These persons are given a low fat diet. Cooked fats (fried foods) are especially avoided. Obesity is corrected if possible. Vitamin supplements, especially the fat-soluble vitamins, are usually required. Occasionally extract of ox bile may be necessary as substitution therapy, but it is important not to give a choleretic, such as decholin, because of the risk of stimulating biliary flow and thereby distending the gallbladder and possibly initiating biliary colic. Some patients find that the prompt use of nitroglycerin or amyl nitrite will relax the sphincter of Oddi and abort an attack of biliary colic. More commonly Demerol or opiates will be required for the relief of colic. Atropine is used in combination with opiates to counteract the tendency of the latter to cause gallbladder contraction.

The treatment of chronic cholecystitis without stones is more controversial. Many experienced surgeons refuse to operate on these patients, because in the past many such patients have not been relieved of their symptoms. This is perhaps due to the fact that the diagnosis of chronic cholecystitis without stones was not based on adequate objective examination and the patient's symptoms were due to some unrelated condition. Bockus has emphasized the importance of expert cholecystography and diagnostic biliary drainage in evaluating these patients. A flat film of the gallbladder before the administration of dye is important in detecting calcification of the wall of the gallbladder. This condition may be obscured by the overlying dye if the preliminary film is not made. The failure to obtain a routine erect film of the gallbladder after the administration of dye may mean that some stones will be missed. There are many conditions unrelated to the gallbladder which may prevent normal concentration of the dye within that organ. The dose may have been inadequate; the dye may have been lost from the body because of diarrhea or vomiting; hepatic disease may mean inadequate secretion of the dye into the bile; obstruction of the biliary tract may prevent the dye from entering the gallbladder; a spastic colitis may lead to reflex emptying of the dye from the gallbladder before a film is exposed; or improper exposure technic may cause the gallbladder shadow to appear faint. If these disturbing factors can be eliminated, and they usually can by attention to details, then the demonstration of a faint gallbladder shadow may be very helpful in the diagnosis of chronic cholecystitis without stones.

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We have learned that the failure of the gallbladder to contract following the administration of a fat meal is of little significance in the diagnosis of organic disease of the gallbladder.

Diagnostic biliary drainage may also be helpful in the diagnosis of chronic cholecystitis without stones. A concentrated solution of magnesium sulfate is instilled into the duodenum through an inlying duodenal tube. In the normal individual this leads to emptying of the gallbladder and the entrance of its concentrated B bile into the duodenum. In chronic noncalculous cholecystitis there may be a failure to obtain B bile even after several stimulations with successive doses of magnesium sulfate because of the inability of the diseased gallbladder to concentrate bile.

The absence of B bile and the faint visualization of the gallbladder by cholecystography are mutually confirmatory signs of cholecystic disease. When they are both present and the clinical picture suggests gallbladder disease, cholecystectomy is the treatment of choice. Actually these patients represent a minority. More than 80 per cent of patients whose gallbladders give rise to symptoms will have stones.

There is a small group of patients in whom both of these signs are not present. Decreased density of the gallbladder shadow after expert cholecystography may be the only abnormality, or the duodenal drainage findings may be equivocal. For this group a trial of medical management may be in order. The therapeutic objectives are a stimulation of bile flow and a flushing of the gallbladder. Accordingly, a high fat diet may be prescribed to cause effective emptying of the gallbladder. If the patient is obese, 5 minims of oleic acid in gelatin capsules may be used after meals as a cholecystogogue in place of the fat. A nonconjugated oxidized cholic acid, such as decholin, may be given as a hydrocholeretic to increase the volume of bile flow and to make the bile less viscous. On the other hand, if fat digestion is impaired due to inadequate bile flow, it may be desirable to give conjugated unoxidized bile acids, extract of ox bile, as substitution therapy. Obviously the success of this treatment depends upon adequate diagnosis. If advanced cholecystitis, with or without stones, is present, such stimulation of the biliary tract might lead to a disastrous exacerbation of symptoms. The insistence on adequate diagnosis is most important.

Much has been written about biliary dyskinesia. It may be defined as a spasm or failure of relaxation of the sphincter of Oddi. The gallbladder if present may be hypertonic or relaxed. In any case there is evidence of increased pressure and dilatation within the biliary tract. I have never encountered a case in a patient who has not had biliary surgery. Certainly not all post-cholecystectomy pain is due to this condition. A diagnostic biliary drainage may demonstrate cholesterol crystals and calcium bilirubinate pigment, which is practically pathognomonic of gall stones; in this case, stones in the common or hepatic ducts may have been overlooked at the time of cholecystectomy. Or the pain may be due to abdominal parietal neuralgia or some other condition entirely removed from the biliary tree. The secretin test for pancreatic function may suggest the presence of biliary dyskinesia in the post-cholecystectomy patient by showing a storage of bile in the common duct. A simple diagnostic test which may confirm the diagnosis of biliary dyskinesia is the administration of morphine to produce a painful spasm of the sphincter of Oddi followed by nitroglycerin to relieve it.

Biliary dyskinesia is treated by relaxing the sphincter with drugs and then flushing the biliary tree and gallbladder (if present) with fatty food. Heavy magnesium oxide, about 0.065 Gm. (1 grain) q.i.d., a.c., is given to relax the sphincter of Oddi. One of the long-acting nitrites may be equally satisfactory for this purpose. Obviously the fatty food will cause an exacerbation of symptoms if the sphincter is not first relaxed.

The medical treatment of cholesterosis (strawberry gallbladder) does not differ significantly from that of cholelithiasis. A low fat diet is prescribed, and if the patient is obese, as is often true, an attempt is made to reduce his weight. Despite this program some patients will have severe symptoms, not unlike those of cholelithiasis including typical biliary colic, and cholecystectomy may be necessary. The diagnosis can be suspected preoperatively if one observes cholesterol crystals, but no calcium bilirubinate pigment, in the B bile of the biliary drainage. There may also be poor visualization of the gallbladder by cholecystography.

The management of stone in the common duct causing biliary colic is based upon the use of antispasmodics, e.g., nitroglycerin or atropine, and narcotics. Only rarely does the biliary tract empty itself of stones physiologically, and cholecystectomy with exploration and drainage of the common duct is almost always necessary. The problem of residual stones in the common or hepatic ducts following cholecystectomy is a special one. Ideally, of course, it should not arise since all stones should be removed at the time of the first operation. In this connection let me say a word for immediate cholangiography during the operation. This procedure may be very helpful in demonstrating ductal stones which are missed by palpation and probing. Certainly before a T tube is removed from the common duct postoperatively a cholangiogram should be made. If stones are found at this time it may be possible to avoid reoperation. Pribram and others have reported surprising success in flushing the common duct with solvents introduced through the T tube. Ether and ethyl alcohol have been used in this manner to dissolve stones. Nitrites may be used to relax the sphincter of Oddi and thus encourage the passage of the stone. The use of such strong organic solvents in the common duct may make a physiologist wince, but if it is successful it is preferable to a second exploration of the duct.

It is wise also to obtain a culture of the bile draining from a T tube before that tube is removed. If an infection is present, a course of a suitable antibiotic is indicated, and special effort is made to demonstrate an obstructing ductal lesion. Stubborn, protracted infection of the extrahepatic biliary tract is usually associated with obstruction of some type. Prompt relief of such biliary obstruction and eradication of the infection are important in preventing the development of cholangitis and liver abscesses. If the T tube has been removed, biliary drainage may be the only method of diagnosing this condition. The presence of cholesterol crystals and calcium bilirubinate pigment in the drainage indicates residual calculi in 95 per cent of the cases and would push one to reëxplore the common duct in patients having symptoms of obstruction or sepsis. The rare case of primary infectious cholangitis may be treated by antibiotics alone.

PARANOID STATE DURING THERAPY WITH ISONIAZID IN PULMONARY TUBERCULOSIS

Report of a Case

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NUMEROUS clinical and experimental studies have confirmed the therapeutic effectiveness of the hydrazines of isonicotinic acid in human tuberculosis.[1] Although a general agreement exists that isoniazid (isonicotinic acid hydrazide) and iproniazid (isonicotinyl-isopropyl-hydrazine) are potent antimicrobial agents in tuberculosis, the exact place of these compounds in the total antimicrobial program still remains to be determined. Iproniazid is superior to isoniazid in therapeutic effectiveness, as judged by roentgenolographic improvement and sputum conversion, but this advantage is negated by its much greater toxicity. Consequently iproniazid is available only for investigational purposes, whereas isoniazid, under various trade names, has been freely available by prescription since June, 1952.

Although isoniazid possesses a relatively low toxicity at therapeutic levels (4 mg./Kg. body weight per day), it should be stressed that its use is not free of toxic effects. Most toxic or side-effects, such as dizziness, vertigo, constipation, headache, insomnia, hyperreflexia and bladder sphincter hypertonia, suggest stimulation of the central nervous and autonomic nervous systems. These findings are generally evanescent and rarely call for temporary discontinuation or reduction of dosage. However, serious manifestations of drug toxicity are occasionally encountered, such as convulsions, psychotic manifestations, blood dyscrasias, peripheral neuritis, hepatic damage, intractable asthma and skin rashes, which require immediate diagnosis and cessation of isoniazid therapy for proper management of the patient.[2, 3, 4]

The following case demonstrates a psychotic reaction in a patient receiving therapeutic dosages of isoniazid.

REPORT OF CASE

B. S., a 34-year old negro male laborer, was admitted to Glenn Dale Hospital on July 15, 1953 for the treatment of active, moderately advanced pulmonary tuberculosis. The family history was noncontributory. The past history was not significant except for serologic evidence of syphilis with negative spinal fluid in 1949, for which the patient received adequate penicillin therapy. There was no history of narcotic or alcoholic addiction. On admission the patient appeared alert, coöperative and oriented in all spheres, with no evidence of abnormal mental behavior and no complaints referable to the respiratory system. Physical examination revealed a well developed and well nourished negro weighing 145 pounds in no distress. The temperature was normal. The blood pressure was 120/80, and except for the liver edge being palpable 1 fingerbreadth below the right costal margin and enlarged inguinal nodes bilaterally, the remainder of the physical examination was not remarkable. Admission blood count and urinalysis were normal, and the blood Kahn was positive (4 plus) with a 1:4 dilution. The spinal fluid was completely normal. Repeated sputum concentrates were negative for acid-fast organisms. Radiographic examination of the chest revealed a light linear and mottled infiltration in both upper lobes from the apex to the third anterior rib.

The patient was placed on modified bed rest supplemented by combined antimicrobial therapy, consisting of streptomycin, 1 Gm. intramuscularly twice weekly, oral sodium para-aminosalicylate, 12 Gm. daily, and oral isoniazid, 300 mg. daily. He remained asymptomatic, and gastric cultures continued to be negative for acid-fast bacilli. Serial chest roentgenograms made October 16, 1953 showed bilateral partial absorption of the infiltration in both upper lobes. The diagnosis was changed from moderately advanced to minimal pulmonary tuberculosis, and combined antimicrobial therapy was continued.

On October 31, 1953 the patient reported to the nurse that other patients were "teasing and bothering" him, making unkind remarks and telling lies about him. After 3 days, during which he at times appeared restless, uneasy and agitated, he was removed from eating in the ward dining room and permitted to eat his meals in his room. At this time an interview elicited mild delusional and paranoid ideas of reference. Thereafter the symptoms partially diminished. During this period chemotherapy was continued, and on November 13, 1953 the patient was transferred to another ward. During the night of November 15, 1953 he became exceedingly restless and agitated. He refused to go to bed and remained awake the entire night, apparently afraid to sleep since he maintained that patients from two other wards were "going to kill" him while he slept. Since these ideas of reference, delusions and agitation persisted, on the next day, November 16, 1953, isoniazid was discontinued, while streptomycin and para-aminosalicylic acid were continued. An immediate and abrupt change in the patient's ideation, speech and psychomotor behavior was noted. He became quieter, more friendly, and gave no evidence of delusions, ideas of reference, or hallucinations. When seen by the consultant in psychiatry on the next day, November 17, 1953, the patient was able to discuss the preceding 2 days without rancor or hostility and appeared to accept them with calmness. The impression was toxic psychosis with paranoid state, due to isoniazid, in remission.

The patient remained calm and stable until December 3, 1953, when once again he suddenly became very tense, restless, and agitated and insisted that other patients were going to beat him with a broomstick and kill him. Delusional ideas and ideas of reference recurred. On the same day the patient was transferred to the Psychiatric Service of the District of Columbia General Hospital. He improved very rapidly, so that on December 8, 1953 he was returned to Glenn Dale Hospital with a diagnosis of paranoid schizophrenia, mild, with toxic factors, or isoniazid psychosis. He remained quiet and coöperative and manifested no evidence of disorientation, hallucination, or delusions. Psychiatric consultation on December 20, 1953 revealed the patient to be congenial and communicative. There was no evidence of psychosis, but it was thought that the underlying paranoid character was in evidence and that the episode of December 3, 1953 was a reactivation of paranoid concern. As of this report, 1 month after the last interview, no new hallucinatory or psychotic episode has occurred. Streptomycin and para-aminosalicylic acid have been given continuously.

DISCUSSION

Recent advances in tuberculosis, particularly chemotherapy, resectional surgery, and home care programs, have stimulated a greater professional interest in tuberculosis among general practitioners and internists. As a result, an ever increasing number of patients are now being cared for at home by their private physicians rather than in hospitals by chest specialists. Physicians employing hydrazides in the treatment of tuberculosis should therefore be familiar with their possible toxic side-effects, particularly those affecting the nervous system. Especially to be watched for are psychotic behavior and aggravation of latent or manifest neuropsychiatric disorders. Early diagnosis of the development of any psychotic or neurotic manifestation will prevent the possibility of fixation of the psychiatric disorder. Immediate discontinuance of the drug is essential, and frequently the psychotic manifestations will clear up quickly.

The sudden development and rapid resolution of a paranoid psychosis was striking in this patient. The withdrawal of the drug produced an immediate change in the psychiatric picture. When viewed by the psychiatrist on November 17, a day after the cessation of the drug, the agitated, excited, and threatening attitude of the patient had disappeared. However, he was still suspicious, uneasy, and sensitive to the attitudes of his fellow patients.

Although isoniazid produces central stimulation, a minority of patients being treated with the drug develop psychotic reactions. In a gross sense, the drug is contraindicated in those patients who already demonstrate some central nervous system instability, such as epileptics. However, the problem of sensitivity is not so easily established when the psychologic picture is more subtle and covert, such as in many neurotic syndromes. Our patient showed no obvious manifestations of central nervous system instability. There was no previous history of psychosis or neurosis or other manifest evidences of gross instability. However, he had always been a sensitive, somewhat shy individual, who had vague feelings of superiority. Consequently, he has felt that people envy him—his looks, his suavity, and his ability to succeed with the ladies. Although he is fairly attractive physically, his phantasied attractiveness is much greater than in reality. He had been somewhat aloof and snobbish before admission to the hospital and often felt imposed upon, and pushed around by various people. His wife walked out on him one day after a quarrel and never returned. He managed a rather comfortable existence, maintaining his job and limited social contacts with women.

Upon admission to the hospital he appeared to be very friendly and congenial and was considered to be a coöperative patient. However, in a short while he began to develop antagonistic relationships with some patients, 2 in particular, who later figured in his delusional system. The patient felt that these 2 men were envious of his sexual prowess and meticulous appearance. They poked fun at him and on several occasions made him the butt of their humor. They became the center of his uneasiness at the hospital, and he felt that they took every occasion to make him look foolish and started rumors about him. The feelings remained well under control until November 14, approximately 2½ months after beginning isoniazid therapy. At that time, they were verbalized and elaborated into a delusional system, with many ideas of reference. Auditory hallucinations occurred, and they became more and more pressing until the patient became quite agitated. He was afraid to go to sleep for fear he would be killed by these patients. The delusional system was quite elaborate and began to involve all the patients and the hospital personnel. When the psychiatrist was called, the patient was involved in a full-blown paranoid psychosis. These symptoms entirely cleared up after isoniazid was discontinued, except for a brief recurrence 3 weeks later. At that time he again expressed concern that these 2 patients would try to kill him. However, no hallucinations occurred at this time.

This case illustrates clearly the underlying personality problems which are activated by a drug which can produce a psychotic reaction in sensitized people. The previous psychologic difficulties are manifest in the psychotic symptoms. This is usually the case in the toxic psychoses and helps us to understand why some individuals are more susceptible than others. In using potentially psychosis-producing drugs, it is very important to know a great deal about the psychologic background of the patient as well as his physical problems.

In the case of isoniazid the psychologic background of the patient should be explored as well as his tuberculous process. When the drug is used, the patient should be carefully watched for the early indications of a developing psychotic process. This is more easily accomplished when the patient is hospitalized. If the drug is used in private practice, it is essential that the patient be seen regularly. This is particularly important, since immediate discontinuance of the drug will usually terminate the psychotic development. However, if the psychotic process is allowed to be continued for too long a time, it may become fixed, and psychiatric therapy becomes extremely difficult.[5]

SUMMARY

A case of a paranoid state induced during therapy with isoniazid in pulmonary tuberculosis is presented. In view of the increasing use of isoniazid, greater professional interest in tuberculosis, and the potential toxic effects of isoniazid upon the central nervous system, it is urged that patients receiving isoniazid be carefully observed for neuropsychiatric abnormalities.

(*Continued on page 414*)

FEAR AND PHOBIAS*

Part I

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FEAR is a universal and disturbing human experience. In the ordinary course of events it is avoided whenever possible. Fear has played a vital role in the survival of our race. The survival of primitive man depended upon his ability to recognize and cope with danger. When confronted by a threatening animal or person he had to quickly choose "fight" or "flight" according to which appeared to be the more appropriate response. Accompanying and perhaps partly preceding the physiologic changes in preparation for such action were certain emotional changes in which fear was often included.

Fear may be defined as "the emotional response to recognized external danger. . . . Fear and its accompanying physiologic alterations constitute a reaction designed to meet the external threat."[1] Fear is an uncomfortable state of apprehension or uneasiness in which the object is clear. It is commonly associated with physical danger, in which fear may be part of the emotional response to a realistic external environmental threat. Fear is likely to be a more circumscribed reaction, whereas anxiety, as the closely related "civilized evolution" of fear, may be more diffuse.

Anxiety, in turn, is the apprehensive tension or uneasiness in response to danger which is essentially internal. In fear the threat is primarily external; in anxiety the threat is internal. This internal danger is present when a disowned impulse or idea, earlier relegated to the unconscious because it was unbearable, threatens emergence into conscious awareness. In other words, the threat of derepression produces anxiety. In contradistinction to fear, the object may be completely obscure to conscious awareness. Lay use of the term fear often includes anxiety.

The close relation of the emotions or affects of fear and anxiety are further illustrated in the close similarity of the physiologic changes accompanying each. Individually specific, these tend to be more circumscribed with fear and normally subside within reasonable limits in the emotionally healthy person following cessation of the stimulus.

When a patient reports his uncontrollable feelings of fear and panic present in association with closed spaces or heights we recognize this as a pathologic emotional process. The fear in these instances is unreasoning and is not subject to voluntary control. This particular kind of psychopathology is termed a phobia. Specific phobias have been named with prefixes on an empiric basis indicating the object feared. Thus the morbid fear of closed spaces is claustrophobia and that of heights is acrophobia. In 1952 the phobias were officially established as a separate group of neuroses for purposes of diagnosis and classification.[2, 3]

A close relationship exists between fear, anxiety and phobias. In our study we shall learn how phobias develop as attempted defenses against anxiety. In the phobic defense the internal threat is transposed or displaced so that it appears to the patient to be a threat from outside. The apparent source of danger, the external object which is feared, can then perhaps be avoided.

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This is the ninth article in a series by Dr. Laughlin covering the psychoneuroses. Part II of "Fear and Phobias" will appear in the August issue of the MEDICAL ANNALS. The final article of the series, "Neuroses Following Trauma," will appear in the September issue.

"Fear and Phobias" will be a chapter in a forthcoming psychiatric text by Dr. Laughlin, entitled "The Neuroses," which will be published early in 1955 by W. B. Saunders Co., Philadelphia, Pa.

Our definition of a phobia is "a morbid fear out of proportion to the apparent stimulus."[4] A phobia is an obsessive, unrealistic fear which is inappropriate and unreasoning. It is beyond voluntary control and cannot adequately or logically be explained by the patient.

FEAR

The protective purpose which fear may serve in apprising us of danger has been noted. C. R. Kennedy in "The Terrible Meek" even referred to courage as "a peculiar kind of fear." Fear is an uncomfortable reaction, and ordinarily one seeks to avoid fear-producing situations. The amount of fear in response to a given stimulus varies considerably from person to person. The outward expression of fear also varies greatly. Common objects of fear have been described as the common phobias, ". . . aversions which are implanted instinctively in everyone,"[5] e.g., fear of snakes, vermin, thunder storms, darkness, illness and solitude. Freud[5, 6] advanced the belief (1894, 1895) that phobias developed in these "common" areas through the use of "available anxiety" with resulting "exaggerated fear of all those things that everyone detests or fears to some extent. . . ."

Although these objects of aversion may approach the universal, there is certainly doubt about both "instinctive implantation" and ubiquity. As we shall learn, these "common" objects of fear are among those which often serve as "convenient pegs" for phobic displacement. The degree of fear varies widely, so that it is often difficult to determine a "normal" or "usual" degree of fear. Indeed, Fenichel,[7] in briefly discussing the question of "whether there is any such thing as a normal fear of death, . . . " even goes so far as to indicate that "probably every fear of death covers other unconscious ideas."

How can we determine, then, when fear is pathologic? Drawing a hard and fast line poses problems. There is a gradual progression from any so-called "normal" fear into, first, a mildly pathologic kind of reaction, then to a more severe one, and finally to frantic states of panic. In general, it can be helpful to raise such questions as degree, appropriateness, and the psychic disjunctive effects. When fear is of such a degree as to interfere with living, with effectiveness and function, or with the ability to develop and maintain constructive relationships with people, professional help is indicated.

As civilization has progressed and social interactions become more complex, fear has changed from the originally simple response of primitive man to external danger. Through the operation of hidden (unconscious) mental mechanisms the "apparent" or "manifest" object of fear may conceal a deeper underlying "concealed" or "latent" object. Modern society requires a degree of emotional maturity in which many instinctual drives and demands must be controlled or redirected in more socially useful and constructive directions.

In instances of delayed or faulty maturation internal conflicts develop and various unhealthy measures are adopted out of conscious awareness in efforts to control, deny or divert disowned thoughts and wishes which are personally and/or socially disapproved. As the objects of fear have become more complex in modern life the responses of "fight or flight" have done likewise. A more involved kind of flight, "a flight into activity," is the defensively intended response illustrated in the following case:

Case 1. *Fear of social relationships.* A brilliant young college girl sought medical assistance because of mild general debility, moderate underweight and nervousness. She was referred as a possible candidate for psychotherapy because of a limited social adjustment and because the referring physician had determined the existence of a certain compulsiveness in her academic work. Study disclosed an attractive but insecure young lady who disclosed her strong fears of social relationships, principally with men. She had become absorbed in her classwork and had secured permission to exceed the usual limit of semester credit hours allowed. This degree of academic absorption was a defensive effort to deny her interests and to divert her attention away from the feared (but still basically desired) relationships. Her real fears were found to stem from large areas of self-doubt. She doubted her ability to make necessary decisions and to adequately handle problems arising from dates. She feared she could not cope with men and with sex. In view of inadequate earlier preparation for social adjustments there was a considerable basis of reality for her self-doubts. This patient was eager to learn more about what made her "tick" as a person. As a result she was able to make rapid and substantial progress in the work of treatment. She was soon able to forego her defensive scholastic preoccupation. Her social adjustment improved remarkably during the course of treatment. Today she leads a successful married life with two children and has taken an active role in community and social activities.

This case illustrates in early and not yet fully developed form a type of mechanism which we shall see increasingly present as we continue our study of fear and phobias. The fear tends to be subjectively experienced and described as though it is of something outside oneself. In this instance it is of social relationships. Actually, as we have seen, there was a displacement externally from things that were feared and doubted in herself, i.e., her ability, capacity and adequacy. Subjectively the threat then appeared to come from feared and avoided relationships. Externalization and displacement will be seen frequently in subsequent examples. They are important basic mechanisms in the development of phobias.

An example similar to the foregoing comes to mind which illustrates the extremes to which attempted psychologic defenses may drive a person. The great amount of defeat, self-deprivation and injury also point out the sad paradox and illusions of any concept of "gain" from the neurotic defensive endeavor.

Case 2. *Fear of vulnerability and hurt through a close relationship.* A 39-year-old lawyer sought character analysis to improve his professional competence. It was early apparent that all his relationships were on the cold and formal side. He had a tremendous need defensively to maintain distance in his contacts with people, professionally, socially, and *en famille*. One day this patient unfolded for me in a highly dramatic session how following graduation he had "deliberately" broken off the relationship with the girl he loved and married another to whom he was actually cold and indifferent. He had attempted to rationalize his action on the grounds that a marriage with strong love present was bound to be followed by disillusionment. He also professed to admire the kinds of marriages which are arranged by families of the couple in certain other foreign cultures as more stable, more lasting. It would "work out better for the bride and groom to be strangers prior to the final ceremony." The rationalizations broke down as we learned this was his desperate attempt to avoid the inevitable hurt, disappointment, and rebuff he so absolutely and certainly associated with any close relationship. He had become so sensitized to hurt in the bitterly disappointing traumatic relationships of early life that no sacrifice was too great to avoid the chance of repetition.

The great amount of restriction and sacrifice so willingly accepted by this patient was some measure of his tremendous fear. We can also question just how "deliberate" such a choice actually was. On the basis of the powerful protective needs present, I doubt how genuinely free a choice he had.

Let us return to primitive man and his more direct fears. Let us picture in our mind's eye a young prehistoric man following a jungle trail to the tribal water hole. Suddenly he is confronted by a sabre-tooth tiger! Fight or flight? If he survived to become your ancestor or mine, he made the proper decision in a flash and had adequate resources to follow it through successfully. Our imagination can perhaps supply us with a number of his alternative responses. We can also possibly form a fairly accurate (and fortunately detached) picture of the composite, physical, physiologic and emotional changes occurring. So much for the immediate handling of the situation. However, how about tomorrow's trip to the water hole? Other things being equal, our young man will tend to take another path.

Associating the disturbing encounter with its locale he will tend to avoid a repetition by avoiding the place where it happened. This may be a sound and practical course to follow. The tendency to avoid pain and seek pleasure is a biologic principle. Fear and fear-producing situations are painful, and it is only human nature to seek to avoid them. Within limits this is healthy and constructive. Where the avoidance becomes unrealistic or self-defeating in neurotic fashion the intended protection is turned instead into a net liability.

Even with our primitive man the avoidance is not necessarily realistic or rational. It is conceivable, for instance, that he might take an alternate path (in avoidance of the locale of his encounter with the sabre-tooth) even though the rest of the tribe had seen sabre-tooth tigers frequently in the alternate path, and perhaps his was the only encounter in the first path. We might also note in passing that the avoidance of the situations associated with fear in our first two cases have a certain similarity to the above avoidance of the tiger trail. This principle of avoidance of the object of fear or fear-producing situations is another important cornerstone in our study of fear and the phobic defensive mechanism. One can see in addition the possibilities for the development of magical ideas, superstitions and rites in the primitive situation. The tiger trail might become evil and taboo. Protective talismans might be set up.

Avoidance can have magical, unrealistic protective significance also for modern man. This is seen in the continuation of superstitions in which some kind of evil is avoided by not walking under a ladder and not having a black cat cross one's path. Recall the proverbial 7 years of bad luck if a mirror is broken. We may laugh at these and know they have no scientific basis yet feel some underlying slight uneasiness about them if a sufficient foundation for superstitious belief has been established. Avoidance, of course, is an important cog in the attempted protection of the phobia through avoidance of the phobic-object, which is often symbolically important.

A similar pattern of protection through avoidance is present in animals. Several years ago our faithful old dog Cookie accompanied me en route to posting a letter, as was her wont. I crossed Connecticut Avenue with my daughter, bidding Cookie wait as usual on the near side of the busy thoroughfare until our return. This time, however, she became impatient. We were held up on our return trip by traffic. As we waited on the middle island, to our horror she attempted to join us despite an oncoming car. She was struck heavily and rolled over and over by the impact. Fortunately she survived and is now a devoted and beloved old family pet. To this day, however, she will not go within 200 feet of Connecticut Avenue. The injury, pain, and traumatic experience were associated with the location. Cookie did not become more cautious about cars. Instead she began to avoid the place of trouble.

This is, of course, analogous to the taboo not infrequently established for the scene of an accident by a driver. A physician friend recently told of driving north through Virginia. A detour in a town led him rather automatically to take another route out from town than the main one but with which he was familiar and knew to be shorter and easier with less traffic. He saw a route sign and suddenly realized he was traveling a route along which he had had a very serious accident some three years earlier. He found himself uneasy and apprehensive. Despite the loss of time and some miles, he retraced his way to the town in order to get back on the original road. Thus we can see the progression in gradual stages from fear to phobia and the simpler origins of mechanisms which are basic to the phobias. Already we begin to approach the phobic response, as the source of danger begins to be attached to external objects.

Compare the above instance of my friend's fearful semi-magic protection sought through a phobic-like avoidance of the route where his accident occurred and a patient who developed a strong phobia of buses. Buses as the phobic object were selected circumstantially in a primitive kind of association mechanism when his first "critical" attack of anxiety-panic occurred while riding on a bus. The patient feared buses and avoided them in his desperate effort to avoid a recurrence of the dreaded anxiety attack.

In the following illustration I would not yet regard the reaction as an actual phobia, but the dividing line continues to narrow. We see here a social fear and its infrequent basis in a judgmental conscience whose condemnation is partially projected.

Case 3. *Fear of being seen publicly with a girl friend.* An unmarried college professor in treatment had spoken at times of his restricted social life. It was not that he was timorous or reluctant to have dates. Actually he had a girl friend of whom he was quite fond. Although they had frequent dates they seldom went out. We were also well aware of the presence of hypertrophied moral standards. His conscience bitterly disapproved of any interests or activities along sexual lines. Consciously, he attributed his social adjustment difficulties to uneasy and fearful feelings which were present whenever he and his girl friend appeared in public. As a result he was restricted from many types of social activity. For a long time intermittent references to his fear and the resulting social restrictions secured little further data. There was no evidence of relationship to the strong conscience, and inquiry led to a blank wall. Finally, certain clues resulted in progress. What he genuinely feared was a projected reflection of his own disapproving conscience. Somehow people seeing him with his friend would intuitively sense or magically gain awareness of his sensual interests and thoughts. To him it was certain that they would share his own harsh judgments and condemn him accordingly.

The source of the threat in "simple" fear is typically external and apparent. Anxiety is closely related as a complex outgrowth of fear. Its evolution has appeared to me to be in response to gradually increasing and progressively complex social and cultural pressures. These pressures have been aimed, over ages of time, at securing individual restraint, repression, control of instinctual drives, and maturity in favor of the greater social gain, progress and civilization.

With the emotions of fear and anxiety there are common accompanying physical and physiologic changes. In the more primitive reaction of fear these played a vital role in preparation for "fight or flight." In anxiety these physical reactions continue but are much less appropriate and, indeed, in view of more inhibitions to any physical response or discharge through activity, they no longer serve their originally intended protective function, but, instead, this damming up of action potential results in increased tension and stress.

When repeatedly present or chronic, the results lead to functional change in individually susceptible organs or systems and, if unrelieved, later to structural changes. An understanding of this process is basic to our understanding of the development or psychogenesis of the so-called psychosomatic or psychophysiologic disorders. Fear exerts great power and control over people. Reason often goes out the window when fear comes in the door.

There are many more important aspects of fear which we cannot consider in this discussion. Ages ago Statius assigned a preëminent role to fear, "*Primus in orbe deos fecit timor*" (the first fear is what made gods in the world). Let me point out that fear is readily transposed into hate of, or anger toward, the feared person. We can perhaps readily illustrate this for ourselves through personal social or clinical observations. It is not as easy to see the reverse process—how hate or anger by projection to the hated person can be subjectively experienced as fear.

Fear and anxiety are closely related phenomena.* Following the biologic principle of avoiding pain, man ordinarily seeks to escape the pain of fear and anxiety. The ego can take many devious pathways which are defensive and protectively intended. We have already seen these illustrated in the discussion of the various types of neurotic patterns. These have included dissociation, conversion, depression, emotional fatigue, overconcern with health, and the obsessive-compulsive reactions. We have also observed and studied the development of certain patterns of character defensive traits, particularly the hysterical, depressive, and obsessive personalities. It is important to stress that while we necessarily categorize and delimit these as apparently specific entities, this is necessary for purposes of convenience in presentation and study. Overlapping and combinations of emotional defenses are more the rule than the exception. Their separate study and understanding is a very useful approach to the almost endless variety of cases seen in clinical practice.

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* Fear and anxiety have been distinguished partly on the basis of the danger being internal or external. This basis is not absolute. As one colleague writes, "I am not convinced of the validity of a sharp separation of external danger and internal danger, and in correspondence with this would tend less to distinguish fears and anxieties, except with the following qualification: fear as a reaction to known danger and anxiety as a reaction to unknown or at least undefined danger." —Nathan W. Ackerman, M.D. (personal communication, June 14, 1954).

The phobias are the major remaining category of defensive reactions against fear and anxiety. So far we have seen how fear and the individual response to it can become increasingly complex. As we have considered some of the more complex psychologic aspects of fear we have already uncovered some of the important components of phobic defense formation. Thus in case 1 we saw how fear and self-doubt about ability to handle the problems which could arise in social contacts were transposed in a short-circuiting fashion into an apparently direct fear of social relationships per se. A condensation took place with a loss (through repression) of several steps in the process and the obscuring of the real source of fear. To this patient the fear is then subjectively experienced as being something external. Externalization is a frequent part of the phobic defense. With the primitive man, with my physician friend, and with Cookie, the source of fear became associated with the locale of the original frightening event. This type of association is a frequent major pathway for selection of the phobic object and one largely neglected in the literature to date. Once such an association has been established the route is now open for use of the rather magical protection sought through avoidance of the feared area.

PHOBIAS

A phobia is an obsessive morbid fear. It is out of proportion to the "manifest" stimulus which, similarly to the manifest content of the dream, is in varying degrees a distorted, condensed or symbolic representation serving to conceal the underlying "latent" stimulus. The primary gain of the phobia, the phobic endogain, is to conceal and deny to conscious awareness the internal source of the fear and danger. The anxiety is attached to the external object by an unconscious mechanism of displacement. The endogain lies in averting anxiety by (1) maintaining repression, (2) diversion and absorption of psychic energy (into obsessive phobic preoccupation), and (3) the now apparently possible "magical" avoidance of the externalized object or situation. We shall see later that this concept of "gain" is actually paradoxical.

The first clinical example of a phobia I have chosen actually shows little further progression from our last illustration as to the gradually increasing complexity of fear. The following case illustrates the rather simple type of phobia in which the feared event is, on a deeper level, secretly desired.

Case 4. *A phobia of nervous breakdown in the spouse.* A 41-year-old civil engineer with a record of excellent professional achievement sought treatment because of certain failures in his familial relationships. Among his initially reported difficulties was a rather marked fear that his wife would suffer a nervous breakdown. He suffered from his apprehension and went to some lengths to save her undue stress or strain. During the first 8 months of intensive and productive work in treatment, some of which was intermittently directed toward this particular problem, we managed to work out the bases for his phobia. As a result it has ceased to trouble him.

Immediately following his engagement, this patient had misgivings about the wisdom of his choice of fiancee. These, and later more definite doubts, he attempted to discard. It was intolerable to him from the point of engagement onward to ever face a formal break-up of his engagement or a divorce from his marriage. This was because of his own stringent moral standards and anticipated judgments by others. As he said, "I could not bear the spotlight of family postmortems. The thought of being in the 'dock' is disturbing and embarrassing. Maybe I've always placed too strong an emphasis on 'the proprieties' . . . . I've always had a terrific need for social conformance and acceptance, as it seemed to me. I could never stand the awkwardness of a disrupted engagement or marriage. . . .

"This fear of mine has been an 'inversion' of my real but hidden wishes to escape. I can see it all clearly now. I guess I've always wanted to escape the unpleasant part of our relationship. These desires have been hidden even though there have been references in some of the day-dreams I've told you about. I recall, too, some of my trapped and helpless feelings about the marriage in the early years.

"If my wife had a nervous breakdown this would accomplish what I've secretly wanted—and it wouldn't involve an angry break-up, or unpleasant scenes. It wouldn't be my fault either. No blame for me, plus absolution for any part I might have played in previous disharmonies. People would say, 'Poor guy, he's been living all along with this neurotic woman!' You see, doctor, this would give me sympathy instead of an accusing finger. I couldn't stand that accusing finger from myself as well as from others and so I had to try and hide such wishes even from myself."

Thus, because of its association with guilt, the wish comes out in disguised form. As the patient described it himself, it became "inverted." Avoidance is attempted instead of the feared event. As a result his wife was protected and received special treatment. This plus his anxiety now continued to punish him (however, now also in disguised form) for his disowned wishes. The phobia deals in neurotic fashion with the conflicts by attempting to hide and conceal the intolerable wishes. Certain implications herein as to antecedent conflicts in childhood we shall leave for discussion in connection with other cases.

Where closed spaces, an animal, or thunderstorms, for examples, become the object of a phobia, the fear and dread which subjectively torture the patient are usually consciously recognized as inappropriate. The level of phobic disturbance varies considerably. The student must appreciate its psychologic defensive intent in the concealment and diversion of awareness from something actually more disturbing and dreaded in the unconscious. Thus the "level" of the phobia gives us an approximation of the level of internal conflict. In the occasional very marked case of phobia of any kind, how terrible must be the underlying disturbance! How feared and dreaded must be the possibility of conscious awareness! How important it must be to maintain the phobic displacement! And one might add, not infrequently, how resistant the patient has to be to therapeutic intervention and how difficult the task of the therapist!

In a paper published in 1894 Freud[5] first presented a "psychological theory of phobias and obsessions." Herein he presented the concept of the "unbearable idea" or experience, the importance of the amount of feeling attached to it, and the comparative psychologic defensive handling of this in hysteria and in phobias. In both hysteria and the phobias the failure of repression (the complete relegation from awareness into the unconscious) of the unbearable idea or experience results in the psychopathologic process. "In hysteria the unbearable idea is rendered innocuous by the quantity of excitation attached to it being transmuted into some bodily form of expression. . . ."* In phobias the painful affect is attached to "other ideas which are not in themselves unbearable."

Often the onset of symptoms can be traced to the time at which an effort to thrust the painful event or idea from the mind seemingly succeeded. Thus, when anxiety is present in inordinate amounts, it is readily detached from its original source and by a process of displacement an external object or situation becomes a substitute. This process takes place completely outside of awareness. Usually from the time that displacement is effected all memory trace is lost (repression) of the unbearable idea or event. An example of this is seen in the following phobia about flowers and their scent:

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* ". . . A process for which I should like to propose the name of conversion." This is Freud's original introduction of a medico-psychologic usage for this term. Conversion hysteria is today officially interchangeable with conversion reaction.[2, 3, 8]

Case 5. *A phobia of flowers.* This rather marked phobia was a major factor leading a 34-year-old chemist to seek psychoanalysis. The sight or smell of flowers, particularly bouquets, sprays and cut flowers, and even more so if they were beginning to wither, brought on intense fear and anxiety. Flowers had become an external threatening object which had to be avoided at all costs. A carry-over (extension) to certain chemical odors was a serious professional handicap. The effects on his life were constant, sometimes serious, sometimes tragihumorous, but cumulatively more than might be supposed or can be presented here.

There was no conscious memory of the time of onset nor could the patient give any rational explanation for his very troubling and uncontrollable reaction. Eventually, however, through associations during prolonged difficult treatment and some collateral suggestions, he was able to recall, albeit with great anxiety, the time of onset. This had taken place in very early years at the time of the death of his father. Before the funeral, the casket rested in the living room surrounded by floral displays. The small boy wandered in alone and suddenly recalled hostile feelings he had had toward his father. A terribly repugnant thought that he was glad father was dead came to mind. The idea, "it served him right," was followed by even more unbearable fleeting fantasies that he somehow shared responsibility for father's death through his own hostile thoughts. It occurred to him that, as a consequence, punishment (through the wrath of God) must come. He had frequently been told semi-seriously by his mother that flowers in bloom reflected God's smile. As His smile faded, so would flowers fade and die.

In stringently condensed form this was the essence of the phobic formation. The unbearable ideas included his hostile reflections, consequent responsibility, and being faced with the wrath of God. He was intensely anxious and fearful. The excess of anxiety readily attached itself to flowers as the phobic object. These were present and so associated in sensory context. They already had a symbolic representation for him of equating God's smile. Flowers always fade and wither; in incurring God's wrath, faded flowers were thus even more ominous to him.

Previously he had loved flowers. From this day on, however, they were the object of intense fear and had to be avoided. Note, however, that the unbearable ideas were apparently successfully repressed from all conscious recollection at the time displacement of anxiety and fear was made to the flowers. Now the flowers became unbearable. This process also illustrates the phobic endogain. It would be impossible to escape his unbearable hostile fantasies, omnipotent feelings of responsibility, or the wrath of God. It now becomes more possible to avoid flowers as the symbolic and hidden representation of these.*

There is another point or so to be noted about phobias from this greatly condensed summary. First, the initiating traumatic situation is just exactly that. The disturbing situation precipitates the phobic reaction but only upon psychologic soil already well prepared for such implantation. Thus the ambivalent feelings toward father already existed and were accompanied by conflict. The sudden death of his father was a tragic situational blow which became associated as the possible frightening omnipotent magical result of his hostility. The final crisis came with the intrusion of the unbearable thoughts. By this time prior events had already determined that the amount of anxiety would be of a critical level, i.e., too great to handle and therefore unstable. Further, the capacity for this to be displaced in phobic formation likely also existed.

Unanswered as yet are questions as to why the capacity for development of phobic defense mechanisms exists with this patient and that for conversion or dissociation or some other type of reaction with another. Does some kind of psychologic dominance develop? Are visual areas dominant for one and various selected somatic ones for another? On the basis of an increased individual psychologic meaning, could such a deeply buried basis determine the direction, site, and type of the later focus of emotional difficulty? The understanding of the determinism of location would indeed be important in psychosomatic disorders.

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* Actually as in Rangell's excellent analysis of a doll phobia,[9] this patient had a hyperacute ability to "find" the object of his phobia, in this instance, flowers. The world seemed to him a rather flowery place. Thus there may be an unconscious seeking of the very object which is feared. The feared object is simultaneously desired and sought out. This recapitulates the original or primary oral conflict and ambivalence over the maternal object of dependency. The unconscious need for the object and the consequences for the concurrent hostility toward it can account for the apparent uncanny ability to "find" it despite the fear and anxiety aroused.

In the oral dependent conflict one must have what one wants but at the same time deny it is wanted. The threatening danger of the hostile impulse in the ambivalence toward the object of dependency is that it might be successful in its aim, perhaps rather magically. The ensuing destruction of the vitally needed object would indeed be a disastrous success.

Further, the self-limiting and restrictive effects of his phobia, the investment of energy in efforts at avoidance, and his suffering despite his best efforts, make the neurotic "gain" indeed paradoxical. The real net result as in every neurosis is defeat, handicap, and loss. Finally, recall that the original basis of anxiety had in it unreal and magical elements which if made accessible can be dispelled in the detached light of objectivity, insight and reason.

Recently a colleague* reported to me a case which very similarly had its onset at the time of the death of a parent.

Case 6. *A cat phobia.* A seriously ill patient of 36 suffered from an intense phobia of cats. Cats had been anathema to her since early childhood although there were dim recollections, substantiated by family members, of an earlier fondness for them. This patient's father suffered from chronic alcoholism. He alternated between being loving and tender and being abusive. The consequence to the little girl was the development of strongly ambivalent feelings. Part of her earlier fondness for and attachment to cats had been a sort of compensation to her in which she also sometimes played with them as standing for father or mother or children.

The father died suddenly from a gastric hemorrhage in a tragic and dramatic scene into which the little girl entered, despite repeated attempts by mother to exclude her. She felt both attracted and repelled by what she saw. Mother kissed the dead man whose lips were stained from the terminal hemorrhage, and then insisted the child do likewise, which she did despite feelings of revulsion. She wondered if the cat might do this also and she recalled her earlier playful identifications. There also entered some of the now unbearable hostile feelings toward father and toward mother also, who had been a frustrating object of dependency. If she had such horrible feelings mother might also die (be killed). Projection and displacement took place. The unbearable feelings were relegated to the unconscious.

The danger was henceforth externalized to cats which were the threat and danger in place of her own feared internal impulses. These had been proven fantastically and disastrously potent. The resultant suffering is both retribution and warning. Preoccupation with the avoidance of, and threat from cats also absorbs psychic danger and protectively binds it so that it is unavailable for even recognition of, or acting upon her repressed hostile impulses. She developed character defenses of compliance and became overly protective and solicitous toward mother, at the same time "acting out" some of her hidden, intensely hostile, competitive feelings as a disguised, self-defeating, partial expression.

The phobic object and its selection have intrigued students of psychodynamics. The emphasis in the past has been upon symbolism. In the early development and study of dynamics this was a requisite. The unbearable idea was considered to be invariably sexual in nature. In an early case Freud[5] traced the origin of a strong phobia of a young girl about wetting herself which prohibited her from venturing far from a toilet. This had been a substitution for intolerable sexual ideas which had been originally displaced. At this time she had been present at a concert which she left to void. It seems to me that the choice of phobic object here was largely based upon association.

In an earlier case (pp. 382–3) the selection of the bus as the phobic object was related to the original overwhelming attack of anxiety occurring on a bus. In still another case cited in connection with the Anxiety Reactions[10] the original critical attack of anxiety occurred while driving a car. Driving became the phobic object, and there was subsequent phobic avoidance of the area as well.

Menninger[11] cites an interesting case originally reported by Bagby[12] of an adult with a phobia of running water. As a child aged 7 she had been wedged among rocks in a stream with a waterfall pouring down over her head. The psychologically traumatic incident with its terrific anxiety and frantic helplessness must have undoubtedly served as a peg for the attachment of deeper underlying conflictual material. Here the phobic object was also determined by association to the immediate surroundings. I have seen 2 phobias of water traceable to sensory context of early, nearly disastrous misadventures while swimming. I also recall a phobia about dirt and germs (mysophobia) in which the phobic object appeared to originate adventitiously by association with the littered, unkempt condition of the dirty hovel in which an uncle-recluse lay very ill. The illness and unbearable ideas about death had stimulated the critical attack of anxiety of such intensity as to be unstable. Many similar examples can be cited to illustrate the important role of association to aspects of the situational milieu at the time of phobic defense formation. These play a large role in the choice of the object for phobic avoidance.

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* Dr. Cecil C. H. Cullander.

In an interesting paper, Lief[13] has invited attention to the important role of the sensory context in determining the selection of phobic objects. He has collected a series of illustrative cases. He points out that "the selection of phobic object when based on the sensory context often has nothing or little to do with the unconscious conflict; it may merely be adventitious. . . ." I would agree with him that this mechanism of selection of the phobic object is "simpler, perhaps more magical and hence more primitive." If symbolism exists, it is deeply hidden. He directs attention also to this association mechanism having been operative with Freud personally. Jones[14] reported a meeting with Freud in Munich on November 24, 1912, in which Freud fainted following an altercation with Jung and Riklin. Freud later described milder but similar symptoms in the identical room on occasions 4 and 6 years earlier. The room was also the still earlier exact locale of his final quarrel with Fliess, to whom he had been strongly attached.

I do not wish the foregoing discussion to detract from the importance of symbolism in the selection of the phobic object but merely to call attention to an important avenue for determination of the phobic object which, as Lief points out, has received inadequate notice. The phobic object may be determined in several principal ways, as in table 1.

The projection and attachment of anxiety to an external object is a protectively intended endeavor. The patient attempts, entirely out of conscious awareness, of course, to bind the anxiety and fear to a less disturbing and troublesome external object which can then be more easily dealt with or avoided. One can compare this attachment to magnetism in physics or to the formation of a compound or amalgam in chemistry. There is a sudden burst of excess anxiety. Its attachment is tenuous and easily dislodged, perhaps partly because there is so much in somewhat analogous fashion to certain unstable chemical compounds. As with iron filings to a magnet, free ions in a solution, or two metals forming an amalgam, the anxiety is attracted (i.e., displaced) to a new and "convenient" object. The

TABLE 1

Selection of the Object of Phobia

The displacement of excessive anxiety usually is made at the time of the critical attack to a substitute external object in the development of the phobic defense. This phobic object is unconsciously determined in several ways. Examples cited are those which show the pathway illustrated as the major one.

1. *Symbolism.* The phobic object is the disguised outward symbolic representation for internal, disowned (unconscious) ideas or drives. Symbolism likely plays some role, even though deeply disguised or slight, in the selection of every phobic object.
   Examples: A. A phobia of travel (p. 390)
   B. A phobia of coughing (see Part II)
   C. Freud's case "From the History of an Infantile Neurosis" (p. 389)[15]
   D. Freud's agoraphobia (see Part II)[14, 16, 17]
2. *Transposition of identity to a specific object or animal.* The phobic displacement is of a parent or more properly of a part of a parental figure. The animal or object becomes the disguised substitute for the feared and threatening aspects of the parent. There is usually some overlapping with symbolism (above), since often there are also symbolic aspects in the transposition displacement.
   Examples: A. A cat phobia (p. 387)
   B. Freud's case of Little Hans (p. 389)[18]
   C. Sterba's case of a dog phobia (p. 389)[19]
3. *Circumstantial, adventitious and by association to the objects, locale or surroundings of the critical attack of anxiety.* This route is simpler and more direct and primitive.[13]
   Examples: A. A driving phobia (case 2, The Anxiety Reactions[10])
   B. The bus phobia (pp. 382–3)
   C. The wetting phobia, and others (p. 387)[5]
4. *A Combination of these.*
   Examples: A. A phobia of flowers (case 5, p. 386); object is both symbolic and by association
   B. Anthropophobia (case 10, see Part II); symbolic and circumstantial
   C. Rangell's case of a doll phobia[9] likely includes elements of all three

convenience is by the availability of things in the immediate environment for association, by semi-existing pathways of symbolism, by transposition, or by some combination of these.

Once the anxiety is so bound the new compound or amalgam is now more stable and difficult to separate. Despite his suffering the phobic patient tenaciously clings to his defensively developed phobia. Further, upon substitution of the new object the old original one is lost to sight. The technical name which is used for the "attachment of emotional feeling and significance to an idea or object" is "cathexis."[4] The attachment to or investment of the new object with fear and threat might be referred to as an anxiety-induced cathexis. A primitive magical counterpart is the assignment of special meaning and significance to the talisman.

The universality of fear has been noted. Morbid fears, those out of proportion to the stimulus, are very frequent. Spock[20] discusses fears in early childhood in very clear fashion, with some excellent suggestions about parental attitudes. He points out that "anxieties are different at different age periods" and discusses the more common fears which are likely to develop from 3 to 5, such as fears of the dark, dogs, death, injury, etc. The transition from fear to morbid fear to phobia is a gradual one in which absolute and sharp lines cannot be drawn. Many factors can contribute. For example, it is almost impossible for a child to be comfortable around thunder and lightning when a parent is obviously frightened. Further, children can be highly perceptive and can often sense the presence of uneasiness despite conscious efforts at dissimulation.

As to age, there are a number of reports of infantile phobias and their treatment. Bornstein[21] reported a case of "Phobia in a Two-and-a Half-Year-Old Child." Schmideberg[22] reported the cure of a train phobia in a 3-year-old. The first case of phobia dynamically interpreted was that of a 5-year-old. In 1909 Freud[18] first published the detailed history of "Little Hans" and his phobia of horses which he feared would bite him. In this now classic case, aggressive impulses toward father were dangerous through the threat of possible retaliation. In the efforts to repress this unbearable idea the threat is displaced from father to horses. The danger now appears in disguised form to be that "the horse will or may bite me." The horse has become a substituted object for the feared retaliatory part of father. The horse can be avoided, father cannot. "Flight" as a response to the object of danger is now possible. Sterba[19] later (1935) published a case in which the displacement of the childhood fear of a person (in this instance again father) important to the emotional life was made somewhat similarly in a dog phobia. In a second detailed report Freud[15] presents another animal phobia beginning before age 4. In this instance the main danger is also projected on to an animal but in more complex fashion.

Phobias seem often to have their initiation in childhood. Frequently the foundation for a phobia is laid down in the years 5 to 8. Phobias are seen to begin frequently in later life. In my personal experience there has seemed to be an increased incidence of phobias in the 30's and early 40's. Menninger[23] reported that about 20 per cent of college students have or have had phobias which sooner or later disappeared in most cases. Certainly it is not infrequent for mild phobias apparently to disappear spontaneously after varying periods of time in early years. Occasionally they reappear. I have heard of cases in which the phobic symptoms were first reported after the age of 70.

The following case summary illustrates the definitive formation of a phobia of theaters in young adulthood in which the dynamics have also been worked out rather carefully and are presented in condensed form:

Case 7. *A phobia of theaters.* A successful young journalist sought treatment because of his lack of success in developing and maintaining meaningful relationships. He had a strong phobia of theaters which had been present for several years since his graduate school days. In his class he was a brilliant and outstanding student who worked inordinately but was somewhat handicapped by being younger than his classmates. The onset of the phobia followed a terribly emotionally traumatic situation in which the highly coveted editorship of the *School Review* was awarded to another, although he was the logical candidate. He was denied what represented for him the pinnacle of success. Greatly disturbed, he had sought out one of his professors, who was also chairman of the editorial board, with little satisfaction.

He was torn by confused feelings of helplessness, murderous hostility, and self-destruction. In an effort to relieve his agitation he went to a theater where by chance he saw the professor. His state of disturbance reached a peak and he fled the theater. The conflict and his desperate feelings in response to it no longer threatened him. The danger was henceforth displaced to the theater. He could not flee from his feelings, but he could flee from the theater. By their displacement to the theater the feelings are lost to awareness, and flight from the theater or its avoidance is possible. Now fleeing from the theater equates fleeing from his feelings.

Let us very briefly condense the background and dynamics. The rage against Professor Ingalls in essence recapitulated an earlier, primordial conflict. Father had been a plodding, non-colorful professional man subject to frequent ridicule by the mother. She, instead, held up a more successful brother as an ideal and goal to the boy. She had always been cold and distant, and the implication was, in effect, "if you become like him then I will really accept you." His hidden and threatening rage against mother was toward the unsatisfactory object of his dependency, who had constantly set impossible standards of achievement for him. This made it impossible for him to ever secure success, i.e., acceptance and love. He had to protectively deny that it was possible to be deserted or unloved. The emotionally heightened goal of the editorship and his intense struggle over it is a reliving of the earlier struggle. Loss of success here symbolically equates failure to meet mother's standards and to gain her love.

In this failure he must face helplessness, nonacceptance, and murderous rage over his frustration to make the parent or parent-object "come across." The failure of his compulsive drive for success touches this off. The phobic defense keeps the awareness of his helplessness, and his murderous rage in response to this, repressed.

The main factor in the selection of the theater was the locale of the final unstable overload of anxiety and tension. There were deeper symbolic elements, however, in that to him a theater was a place where one shows off or makes a spectacle of oneself. This conformed to some of his fantasies at the time, which, if followed through, symbolically became a revenge on the standard-setter, a revenge for failure, however self-defeating. The theater also represented the feared and dangerous situation where such impulses might not be controlled.

In this case we see the successful treatment of the phobia accompanied by "cure" of the capacity for phobic defense development. Ultimately, the patient came to accept his helplessness and his inability to gain the fantastic mother of his unconscious wishes and longings. Only then could he accept failure to succeed, give up compulsive working, and allow the risks of close, significant, and constructive relationships. It must be noted that this summary presents only the barest of details in the necessary stringent condensation required. There were many other ramifications and details in this complex case. Treatment required hundreds of hours over several years.

In the following phobia of travel the displacement served symbolically to represent deeply rooted but consciously disowned fears of loss of the dependent position—ultimately the object of the dependent needs, mother.

Case 8. *A phobia of travel.* A young business executive who sought analytic treatment had suffered for years from a fear of travel. The fear had been of sufficient severity to handicap his business considerably. This involved the production and distribution of machine tools, individually designed, for the special needs of various manufacturers around the country. He had consciously rationalized his fears on the basis that something vaguely evil might befall or that, for example, he might become ill with adequate medical care unavailable. Intellectually he recognized the fear and anxiety stimulated by the prospect of travel as most inappropriate in degree.

During the course of his analytic work we occasionally found data which related to this particular segment of his emotional difficulties. Gradually it became clear that a fear of the "unfamiliar" and of "being on his own" underlay the earlier advanced fears. This in turn slowly crystallized as uneasiness about being independent or about taking a more "active position." To him this was implicit to travel as opposed to the more passive position possible in his usual business surroundings. Actually he poorly tolerated separating himself from his familiar and accustomed sources of support, emotional "supplies," protection and dependency.

This separation in effect recapitulated early childhood primordial fears of separation from his mother. These fears, which had been banished from all conscious awareness, had had their ultimate realization in the death of the mother when the patient was 6 years old. He had been an only child, overprotected and overdependent, and her sudden death had been a great shock and loss which at that time left him in precipitate fashion more alone, independent, and on his own. In contrast to other cases thus far illustrated (cases 5, 6 and 7), there was, however, no sudden or dramatic onset. Instead, the phobic problem had developed gradually. This case is not dissimilar in this respect nor in dynamics from certain instances of agoraphobia, the fear of open spaces, and other kinds of phobia.

To mention briefly another aspect of the dynamics, in this situation the original object of dependence is not only desperately important, but almost inevitably also it has directed toward it ambivalent negative feelings. Such proved to be present with this patient with some resulting guilty, rather magically omnipotent feelings of responsibility for her death. In this sense her loss was also a punishment for the negative side of his ambivalent feelings. The death of mother had played a very major role in his personal psychology. All negative aspects in relation to mother were rapidly sent into limbo as a process of idealization took place. Soon with any problem or disappointment he retreated to the comforting thought that "everything would be O.K.—if only mother were here."

It is not surprising in this emotional constellation that fears were also present about my absence on the occasion of trips or vacation periods. His reactions to me were as if I were mother. My patient was eventually able to put some of his feelings into words which also related these instances to the earlier painful occasion: "I am powerless again. I don't like it when you go. It is painful to me. I feel frightened and deserted and somehow both guilty and punished. I would like to prevent it but of course I can't. I feel frantic and helpless." His references to guilt and punishment are a result of poorly hidden hostility and resentment toward me in view of his powerlessness (as with mother). In childhood originally one defense against this was a "flight into omnipotence," in which it seemed somehow as though magically his negative wishes had become terribly and frighteningly potent and succeeded in bringing about the loss of mother.

While the defense of omnipotence can seemingly protect against helplessness or powerlessness, the danger that the negative side of the ambivalence might ever achieve its ultimate aim, i.e., the desperately self-defeating destruction of the simultaneously vitally needed object of dependence, is terribly alarming. Thus anxiety became increased. On a deep level of unconscious mental processes the patient fears that his anger will in some omnipotent fashion achieve its desired but self-defeating result. In a compulsively repetitive fashion, as earlier and stronger with mother, I am the needed object of dependency, although simultaneously resented for my incompleteness and failures to fully satisfy his hidden needs.

Thus, in complex fashion my absences recapitulated the earlier original situation, and in effect rekindled the early conflicts about mother. These had been unfortunately greatly intensified in view of her death, which took place at a time when the patient's negative ambivalent feelings were very strong. There is, of course, a relationship between the patient's fear of his own travel and his fear of my absences. His fear of his own travel was greater partly because the initiative for making the trip with its attendant and earlier stated symbolic meaning was his own. The intensity of fear about my travel is partly a reflection of the level and intensity of the transference. This case illustrates again the displacement of fear out of conscious awareness.

This case can serve to illustrate the mechanisms most frequently present and the technical terms most often likely to be employed in cases of phobia. Let me recapitulate and summarize the dynamics. First, *repression* had taken place and the patient no longer had conscious awareness of his early negative *ambivalence* or *dependency needs*. The former had been *replaced* by a *reaction of the opposite* (*reaction formation*) with an *idealized* image of mother in which her return would solve any problem. The anxiety has been *projected* on to the idea of travel. The latter is the *phobic object* which is a *substitution* for the original disowned internal areas of concern. *Externalization* has occurred with the feelings of the unbearable ideas bound or *cathected* through the important mechanism of *displacement* to a new area. This is an anxiety-laden cathexis. *Phobic avoidance* now becomes a defensively possible maneuver.

In this case travel is the disguised outward *symbolic* representation of inner hidden and disturbing ideas and needs. This entire complex process is in the service of controlling, denying, or allaying anxiety. It brings about the *phobic endogain*, i.e., the *primary gain* of this emotional illness. The gain is desperately sought and main-

(*Continued on page 414*)

President's Page

AS I SEE IT IN JULY

As this first message to the Medical Society membership is written, I have just completed my apprenticeship by serving on the Executive Board as President-elect. It has been an instructive year, in which I have learned quite a bit about local medical problems and the intricacies of medical organization. I have also discovered that being President of the Society is a big job. It not only consumes a lot of time, but keeps one on the job many late hours.

The President-elect is required to appoint all Committee members before July 1—nearly 300 in number. Obviously, they must be chosen with care, for they are the real work horses of the Society; the President can do little without their help.

There are many worth-while projects now in progress, and new ones to be initiated. It is my hope that these may be furthered during the coming year. A few of those in the embryonic stages are:

1. A program which would eliminate the duplication of program material presented by the larger medical organizations and institutions of the Washington Metropolitan Area.

2. An adequate health program for school children, in which the Society and the District of Columbia Health Department would coöperate.

3. An accident prevention program, especially as it relates to the child in the home.

4. A program designed to aid in the prevention of juvenile delinquency.

5. The establishment of a health museum, embracing the principles of the Cleveland Health Museum.

If any or all of the above projects reach a stage where approval of the Society is sought, detailed information about them will appear in the ANNALS and in communications directed to members.

In the meantime, I wish all of you a pleasant summer.

Preston A. McLendon

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PRESTON A. McLENDON, M.D.

President, The Medical Society of the District of Columbia, 1954–1955

Editorials

PRESTON ALEXANDER McLENDON, M.D.

Although Dr. Preston Alexander McLendon, 88th President of the Medical Society of the District of Columbia, is not a native of Washington, he has practiced in the city of his adoption for more than thirty years. Widely recognized as one of the country's leading pediatricians, he is held in high esteem by his fellow practitioners, not only as a clinician but as a teacher and leader in medical affairs. Forthright and friendly, he has a host of friends in and out of the medical profession.

Born in Wadesboro, North Carolina, on March 20, 1893, Dr. McLendon is the son of the late Dr. Walter J. and Sarah Josephine Polk McLendon. He received his early education in the public schools of Wadesboro, later attending Wake Forest College, where he obtained his Bachelor of Science degree in 1913. He graduated from the College of Physicians and Surgeons, Columbia University, in 1915. Internship followed, at Bellevue Hospital, New York City, in 1916–17, and at Children's Hospital, Washington, D. C., in 1919–20.

Dr. McLendon was licensed and began practicing in the District of Columbia in 1920. Subsequently he became Attending Physician at Children's Hospital; Consultant in Pediatrics at Columbia Hospital for Women, Glenn Dale Sanatorium, Prince Georges County Hospital, and the National Institutes of Health's Clinical Center; and Chief of the Pediatric Service, George Washington University Hospital.

He has been Professor of Pediatrics, George Washington University School of Medicine, since 1943. He has lectured at the Southern Pediatrics Seminar for several years.

Among the organizations of which Dr. McLendon is a member are the American Academy of Pediatrics, the Southern Medical Association (he was Chairman of its Section on Pediatrics in 1953), Hippocrates-Galen, Smith-Reed-Russell, George Washington University medical societies, Sigma Psi, and the American Medical Association.

Dr. McLendon was commissioned a Lieutenant in the Medical Corps of the U. S. Navy in May, 1917. In 1918 he was assigned to the Second Division, Marine Brigade, A.E.F. He saw action with the Fifth Regiment at San Mihiel, Blanc Mont, and the Meuse-Argonne, and served with the Army of Occupation. In recognition of his services, he was awarded the Distinguished Service Cross, the Navy Cross, the *Croix de guerre*, and the French Regimental Citation.

Actively interested in community affairs, he has been a member of the Advisory Board of the Salvation Army, and is now on the Board of Directors of the Children's Protective Association and the Advisory Board of the Institute of Mental Hygiene.

Dr. McLendon was married to Mary Thompson, of Alexandria, Virginia, in 1921. The McLendons have two children, a daughter, Mrs. John F. Westfall, the wife of a physician and mother of three children, and a son, Preston A., Jr., who lives with his wife on the McLendon farm in nearby Virginia.

These are facts about Dr. McLendon, but they are far from telling the whole story. He readily admits that he has always been of an adventurous turn of mind. He related a short time ago how, in 1915, before interning, he and

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia.

some of his associates in medical school were employed by the Serbian Government as physicians to the civilian population. (Few Serbian physicians were available, due to their service with the Army and their decimation in the typhus epidemic of 1914–15.) This little group arrived in Serbia only six months before that country was overthrown by the Bulgarians and Hungarians. On the way over Dr. McLendon was one of the first persons ever to be vaccinated against typhus.

On leaving Serbia, he and three of his companions returned home by way of the Central Powers and had the good fortune to visit Sofia, Constantinople, Budapest, Vienna, Berlin and Rotterdam. He arrived in New York just in time to begin his internship at Bellevue.

Long an avid sportsman, he says that he has hunted and fished in the Everglades of Florida and on the prairies of Saskatchewan, and in North Carolina, Virginia, and South Dakota in between. In later years he has been content to do his hunting and fishing on his farm in the Blue Ridge Mountains near Winchester, Virginia. When he talks to his friends about this retreat, which overlooks the Shenandoah Valley, he has a most nonprofessional look in his eyes.

Those who are privileged to know "Mac" always find him a gracious and thoughtful companion. There is an air of optimism and warmth about him which endears him to his friends. These characteristics will soon become apparent to the members of the Society who have not had the privilege of knowing him personally.

The Society is unusually fortunate in having as its President this year a man who is held in such high regard by his colleagues and whose fine qualities as a man will permeate all of his official acts.

SOURCES OF ERROR IN LABORATORY PROCEDURES

When laboratory results do not correspond with the physician's estimation of a patient's illness, the clinician is apt to believe that the laboratory personnel have been negligent. In fact, he is very likely to say so in no uncertain terms, with such expletives as he may feel are appropriate.

Now it is true that laboratory technologists may, on occasion, make mistakes. But as a group they are just as conscientious and dependable as the members of other professions allied to medicine.

Simply stated, my point is this: The laboratory technologist is accused of far more errors than she makes. Others along the line may make the errors, but she gets the blame.

Here are a few illustrations from actual instances in my case-book. All are taken from the laboratory service of a busy general hospital where house officers collect all venous blood and send the specimens to the laboratory.

A. *Error in specimen collection, laboratory not at fault*

1. A patient receiving anticoagulant therapy for myocardial infarction had one of a series of prothrombin determinations seriously out of line with the rest. It was later learned that too little blood had been collected for the amount of anticoagulant in the specimen tube; this excess of anticoagulant interfered with the test. (The amount of anticoagulant in prothrombin tubes is proper for a certain measured amount of blood.)

2. A patient had an unexpectedly high non-protein nitrogen value, not confirmed by a subsequent test. Later it was found that the specimen was collected in a tube containing ammonium oxalate; the nitrogen from the NH_4 was naturally included in the total non-protein nitrogen, giving an abnormally high value. (Ammonium oxalate is a satisfactory anticoagulant for hematologic studies, but not for BUN or NPN.)

3. A patient had an unexpectedly low leukocyte count (2,000 per cu. mm.) in a test done on venous blood. A repeat count showed 10,000 leukocytes per cu. mm. It was later learned that there had been some difficulty in collecting the first specimen of blood and that a clot had formed in the syringe before the sample was transferred to the vial containing anticoagulant. The clot was removed by the house officer before submitting the sample. (Clots entrap the cellular elements, reducing cell counts made on the unclotted portions. Our technologists are instructed not to do hematology studies on bloods containing even minute clots, but they cannot be expected to avoid the error if the clot is removed before the sample is submitted.)

4. In another instance the red blood cell count was unreasonably low in relation to other studies. The blood had been collected in a wet syringe, and many red blood cells had been destroyed by hemolysis. (Dry syringes should be used, or else they should be rinsed with saline after washing.)

5. A blood potassium level was unreasonably high for the clinical condition of the patient. Again the blood had been collected in a wet syringe and hemolysis had liberated the intracellular potassium into the serum. (Blood cells contain much more potassium per unit volume than does serum. Blood chloride determinations are affected in the same way by hemolysis.)

B. *Error in identification of specimen or report, laboratory not at fault*

1. A mild transfusion reaction occurred. Recheck of the patient's original sample revealed type AB, Rh positive, and the patient's sample was perfectly compatible with the donor's on crossmatch. A new sample was collected on the patient and found to be type O, Rh positive. The first sample was clearly marked with the patient's name. The other patient in this double room on the same day was type AB, Rh positive, and the only reasonable assumption was that blood had been collected from the wrong patient. (In hospitals having well-run blood banks, clerical error of this sort is more frequently the cause of transfusion reaction than is technical error in test performance.)

2. A positive serologic test was negative when repeated. The blood sample submitted to the laboratory had been identified with the patient's last name and first initial and with the patient's room number, but it turned out that there were 2 patients with the same last name and first initial in this room. The other patient of the same name was shown by subsequent test to be syphilitic. (Confusion of common names is an important source of error in any large hospital; it can be avoided only by using a check system of specimen identification and reporting, such as hospital number plus full name.)

3. A patient had a very low hematocrit that was unexpected. After checking everywhere it was finally noted that the report attached to the patient's chart did not belong to that patient at all. The laboratory slip, properly identified, had simply been attached to the chart of the wrong patient.

C. *Error due to delay in transmission of specimen to laboratory*

1. A fasting blood sugar determination preceding a glucose tolerance test was too low. It was found that the sample had been kept at room temperature on a hot day until all specimens of the tolerance test had been collected (5 hours). (Glucose in blood may fall as much as 10 per cent in a 2-hour period of standing at room temperature, due to glycolysis.)

2. A sedimentation test was low normal, out of keeping with other tests on the same patient on previous days. This specimen had also stood for several hours at room temperature before being submitted to the laboratory. (For reasons that are poorly understood, red blood cell sedimentation is slowed by standing at room temperature; the effect is usually not significant until after about 3 hours.)

D. *Test interference by medications, laboratory not at fault*

1. There was an unexpected high output of phthalein dye in a patient undergoing a kidney function test, in fact, more than 100 per cent of that injected! Later it came to light that the patient had been given an injection of bromsulphthalein as a liver function test shortly after the PSP dye had been injected. The test for PSP in the urine could not differentiate this dye from the BSP, and the test reading was a total of both dyes being eliminated. (Incidentally, these dyes remain in the blood for a significant period of time and not only interfere with each other but with any test based upon a colorimetric procedure, such as cholesterol, bilirubin, etc. These dyes in the urine will also interfere with sugar and acetone tests in the urine.)

2. A blood prothrombin time was unduly prolonged. It was learned that the blood had been collected only a short time after the patient had been given an injection of heparin. (The chief anticoagulant effect of heparin is not a result of interference with prothrombin, as is the case with dicumarol; however, heparin will depress the prothrombin activity if the test sample is taken within an hour or so after heparin has been injected. Other medications that will depress prothrombin activity are salicylates in large doses, caffeine and the saponins in digitalis leaf.)

3. A patient showed no urobilinogen in stool or urine although bile was present in the stool. The surgeon was certain this was physiologically impossible. A few weeks later a report appeared indicating that aureomycin, by interfering with bacterial action in the intestinal tract, prevents the normal conversion of bilirubin to urobilinogen. The patient in question was receiving aureomycin.

4. We have had many instances in which a remarkable blood level of glucose, potassium or chloride was obtained, later traced to intravenous therapy. Similar effects following intravenous therapy may be noted in the chemistry of the spinal fluid or other cavity fluids.

5. A patient thought to have obstructive jaundice, with complete absence of bile from the stool, showed urobilinogen in stool and urine. It was learned that the patient had received a gallbladder dye shortly before the test was run and that this dye would give false positive tests for urobilinogen.

E. *Error in interpretation, laboratory not at fault*

1. The "biologically false positive" serologic test for syphilis is now so commonly recognized that few well-informed physicians think of this as laboratory error any more.

2. A patient admitted with neurologic findings, and a presumptive diagnosis of brain tumor, showed a high glucose level in the spinal fluid. What was originally considered by the clinician as laboratory error turned out to be the clue to impending diabetic acidosis in his patient.

3. A patient suspected of having hyperparathyroidism had a normal serum calcium level. The clinical impression was so certain that the calcium determination was considered to be in error. It was later learned that the blood proteins were quite low. Therefore, the protein-bound calcium would also be low, thus reducing the total serum calcium as tested. In such cases hyperparathyroidism may be present at the same time that the total blood calcium is within normal limits.

4. A patient under dicumarol therapy had one prothrombin determination considerably out of line with the others in the series, and the laboratory was called to task. On the same day the patient had a marked rise in temperature. (Fever is known to accentuate the anticoagulant effect of dicumarol.)

Many other illustrations could be added, but these are enough.

Dependable laboratory results require that the technologist be competent, honest, and conscientious. But this is not enough. Every possible source of error along the line must be controlled. Even then, the findings may not coincide with the results anticipated. In some instances the discrepancy may provide an important clue to the diagnosis. In others, the discrepancy may be related to unknown factors, not understood in the present state of our knowledge.

Clinicians should be sufficiently informed about laboratory procedures to understand these pitfalls. If laboratory findings are not in accord with clinical judgment, other possible explanations should be considered before the laboratory personnel are accused of negligence.

T. M. P.

THE GENERAL PRACTITIONER'S SHRINKING FIELD

When a group of general practitioners meet in discussion of their problems, an appropriate theme song would seem to be the old spiritual, "Nobody knows the troubles I've seen." In the past 10 years there have been momentous and in some ways grave changes in the practice of medicine by the family physician in the Washington area. Some of the factors which have led to these changes could in no way have been foreseen or prevented by the profession. Other factors are directly attributable to the change in patient-physician relationship largely fostered by the physician himself.

A few short years ago the family physician operated in a comparatively circumscribed area of the City, with a few of his patients in more distant locations. The doctor was able to make his necessary house calls quickly, and his office was easily accessible to the majority of his patients. The wave of migration to outlying districts by the thousands of middle-income families, which group constitutes the bulk of the family physician's practice, was slow and insidious at first but eventually became almost catastrophic. The house call was the source of a large percentage of the general practitioner's income, and 20 calls daily was not too great a burden. With present traffic conditions and distances to be covered, 6 to 8 daily house calls are frequently all that can be made. Also modern drugs have played a large part in changing the picture of home treatment. No longer are there protracted acute illnesses necessitating daily calls for long periods.

The constantly increasing number of families covered by comprehensive insurance plans including obstetrical care, added to the curtailment of certain privileges in most hospitals, has led to a material lessening of the number of deliveries by the general practitioner. With practically all expenses paid, many expectant mothers understandably employ the services of an obstetrical specialist, who, after the delivery, frequently advises the mother to secure the services of a pediatrician to care for the potentially new patient for the family doctor.

The loyalty of the worth-while patient who comes to the family doctor, no matter from what distance, and who waits patiently for the doctor and friend when it becomes necessary for him to come to the home, is one of the most satisfying aspects in the practice of medicine. Questions asked of a large number of doctors in various age groups elicited the information that those in practice from 20 to 30 years or longer enjoyed the loyalty and continuing dependence on them of the great majority of their patients. From younger groups questioned came the rather startling statements that the yearly change in their patient roster ran as high as 60 per cent, with an average of 35 per cent. Such figures would seem to indicate something lacking in the attitude of the younger physicians. Does the answer to the question implied by these figures lie in the fact that current medical education is turning out scientists rather than doctors and that the younger physicians, as often charged, are treating diseases rather than people? Are they failing to strive to become the friendly, always welcome family doctor who is an intimate, integral part of American life? If they are, they are failing to achieve the most satisfying compensation in a life dedicated to medicine.

One well-known family doctor, whose son plans to follow in his footsteps, recently stated that he is becoming less and less sure that he wants his boy to study medicine. "From present trends," he said, "I am afraid that the practice of medicine in the future is not going to be much fun, with little compensation in either money or inner satisfaction."

Moving to the new large real estate developments is not a solution of the problem. First, the houses are small and not suitable for alteration. Office space other than in the home is seldom available. More important is the constantly shifting population in these new areas.

The solution would seem to be in the selection of a cheerful, clean, well-equipped office in a reasonably central location and the fostering of improved patient loyalty by evidencing greater interest in the patient as a person.

In rural areas and in the smaller towns the problems faced by city physicians, particularly in the Washington metropolitan district, are of little importance. But here also the vast majority of families prefer to be associated with a general practitioner whom they can call upon at the first indication of illness. They are sure of his sympathetic interest and feel secure in the knowledge that he can and will procure the assistance of well-qualified specialists should such help become necessary. The general practitioner of today is well-trained and well-read. His keen interest in keeping up to date is attested by the amazing growth of The American Academy of General Practice, with its membership requisite of postgraduate work, and by the attendance at the midyear conventions of the American Medical Association.

In spite of all his problems and troubles, the family doctor is here to stay.

R. L. S.

BARNSTORMING FOR HEALTH

One night in the early 1930's, while syphilis was still rated by Osler as "the great killer," and gonococcal infections with their complications also continued to maim, sterilize, and occasionally prove lethal, Drs. Prentiss Willson and William Alanson White were presiding over a joint meeting of the D. C. Medical Society and the D. C. Social Hygiene Society in the former's auditorium. Both the able obstetrician and the altruistic psychiatrist agreed (1) that a major need was for health education and information for the public regarding venereal disease hazards, and (2) that physicians were the most logical teachers and informants.

Even as the gavel was sounding adjournment, volunteers were heading for Dr. White to sign up for early duty. It was your reporter's pleasant task to complete the informal enlistment roster and discuss assignments. And among its most pleasurable aspects were the doctors' willingness to accept travel orders for talks anywhere from Chevy Chase to Anacostia plus their virtually universal refusal of gas, oil, taxi, or other travel expenses from Social Hygiene's scant budget.

Whether it was Jim Gannon heading with us to one of the District's largest bakeries, Edith Seville Coale talking to laundry workers from a handy soap box, Helen Gladys Kain addressing an audience of waitresses and cooks, Russ Fields or Walter Stokes citing Galen et al to dairy and cafeteria workers, George Creswell organizing the Syphilis Journal Club, or any other of the many medicos who ultimately served in the lecture brigade, there were real verve and *esprit de corps* in this campaign.

Nor should we overlook the valiant services rendered by Drs. Frank Jones, Paul Cornely, Wendell Freeman and others of their Medico-

Chirurgical colleagues. Dr. Jones was particularly deft in the question-and-answer period following lectures. After one of his talks to 50 or 60 employes of a leading hotel, a bus boy declared, "I got my original attack [gonorrhea] from helpin' 2 other fellows lift a piano." Commented Dr. Jones, "That's as 'original' an attack as I ever heard of. It's a rare piano that carries gonococci. Hereafter you'd better stick to your own work and avoid furniture moving!"

Then there was the incident of a fledgling physician, newly elected to the D. C. Medical Society, whose main slogan for dealing with a young male audience was "Scare the devil out of them!" We were riding with him to the hall where he was to give his first talk. En route we tried to persuade him that the diseases and their possible results were dramatic enough in themselves without any additional dose of fear psychology, but without success. It was a hot summer night, and the crowded, unventilated hall was conducive to mal de mer even before the young doctor started, so we went outside, lighted up a cigar, and awaited candidates for stimulants. We were a trifle surprised, however, but also a trifle gratified when the fifth lad carried out for smelling salts and ammonia was the young doctor himself, ashy of countenance and green of gill. Then we had to go in and finish the performance.

Those were the days before the chemotherapeutic marvels of sulfa derivatives and antibiotics, days when the arsenical and bismuth therapy for syphilis took from a year to 18 months, and when neither the diagnostic nor treatment procedures for gonococcal diseases were really specific. Above all, these were the days when long-entrenched taboos had to be broken down ere press and radio would broadcast essential information in the V.D. field or the public would listen and heed.

Hence, to those Aesculapian pioneers who contributed so greatly to the enlightening processes that initiated such excellent results, we raise our *spiritus frumenti* and drink a heartfelt toast of appreciation. We fain would drink separate libations to each of the host of unsung local physicians who has allied himself so helpfully to the social hygiene forces in this crusade. Alas, though, neither our body, mind, nor pocketbook could stand such wholesale salutations. So perhaps these allies will accept token recognition as we quaff a jigger to the 3 notable physicians and humanitarians who have served as presidents of the Social Hygiene Society over the past 23 years, William Alanson White, Henry H. Hazen, and William P. Herbst. Possibly down the centuries there may have been a finer trio to work with, but, if so, we fail to recall them.

Ray H. Everett

GAMMA GLOBULIN AND POLIOMYELITIS

In recent years gamma globulin has been used in an attempt to prevent or modify poliomyelitis. Following its use there has been considerable controversy as to its efficacy. A letter has been addressed recently to members of the Medical Society of the District of Columbia indicating the position of the Metropolitan Health Officers' Association which, on June 2, 1954, adopted the following resolution: "RESOLVED that on the basis of the report of the National Evaluation Committee on Gamma Globulin Used in 1953, this body is convinced that gamma globulin is of no value in the prevention or modification of poliomyelitis."

The above resolution was arrived at after considerable discussion of reports which have been made relating to the use of gamma globulin. One of the reports discussed at length was that appearing in the *Journal of the American Medical Association* of March 27, 1954, entitled, "Evaluation of Gamma Globulin in Prophylaxis of Paralytic Poliomyelitis in 1953—Summary of the Report of the National Advisory Committee for Evaluation of Gamma Globulin," which had been synopsized in *The AMA Washington Letter*—No. 60, as follows:

> NO BENEFICIAL EFFECTS FROM GG: Gamma globulin inoculations have demonstrated no beneficial

effects, a Public Health Service-sponsored committee of experts announces. The group, after evaluating Nation-wide data on last summer's inoculations, reports that: (1) Observation of communities where mass child inoculation was carried out does not provide sufficient evidence to determine the efficacy of the serum in preventing the disease or alleviating its effects. (2) Mass inoculations usually occurred after the epidemic peak, thus reducing evidence of its effect on the epidemic. (3) Family-contact administration of the serum (where all household members were inoculated immediately upon recognition of a polio case) did not appreciably lessen subsequent family incidence of paralytic polio. (4) Inoculation of exposed persons caused no measurable difference in the severity of ensuing paralysis. (5) More experience and greater opportunity for scientific investigation is necessary for proper evaluation of gamma globulin in mass inoculations. The group, composed primarily of physicians, made its findings public after a three-day session at the PHS Communicable Disease Center in Atlanta, Ga.

Spokesmen for the Health Resources Advisory Committee of Office of Defense Mobilization said later that "ODM is prepared to continue administering the distribution of gamma globulin for polio next summer, provided a satisfactory plan is agreed upon. . . . But (regardless) there would seem to be no reason . . . why it could not be distributed . . . and used by doctors as they see fit."

Some of the questions about gamma globulin in relation to poliomyelitis have been well taken in the editorial appearing in the *New England Journal of Medicine* of April 29, 1954, entitled "Misunderstanding and Confusion," which is quoted herewith:

> As recently as March 14, the opinion was expressed in a widely circulated column[1] that "it is unfortunate that some of the conflicting interpretations on the technical aspects of the efficacy of both gamma globulin and the trial vaccine have been aired publicly, for the result has been to create misunderstanding and confusion." But is it unfortunate?
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> Before this question can be fairly answered certain facts need consideration, not the least of which is that $19,000,000 of the public's money is to be spent on the 1954 gamma-globulin program of the National Foundation for Infantile Paralysis[1] and 3,000,000 to 5,000,000 c.c. of Red Cross gamma globulin are to be distributed and presumably administered.[2]
>
> The judgments of the National Advisory Committee for Evaluation of Gamma Globulin are clear enough: "There were insufficient data in the 23 communities in which mass inoculations were carried out to permit the Committee to conclude whether or not gamma globulin had an effect in preventing or alleviating the disease" and "the 'family contact' use of gamma globulin did not measurably reduce the number of subsequent paralytic cases in these households."[1]
>
> Confusion is created when the head of the National Foundation for Infantile Paralysis, a layman, interprets the Committee's conservative abnegation as an affirmation in a way that implies Committee endorsement: "What the Committee did say was that the mass inoculation methods were not used in enough places at the right point in the course of a polio epidemic in 1953 to provide enough information to enable the committee to reach any definite conclusions as to its effect."[1]
>
> If there is "misunderstanding and confusion" about the status of gamma globulin, it has been brought about by radio voices that trumpeted the precious protein during the campaign for funds as though it were almost a cure and, at least, a satisfactory preventive for poliomyelitis. There is little misunderstanding in scientific circles, where few disinterested workers believe that gamma globulin is an epidemiologically effective preventive of poliomyelitis—or that it can become one, no matter how many millions of dollars are spent, and no matter how many uninformed broadcasters volunteer their enthusiastic endorsement.
>
> Three points were originally at issue: whether gamma globulin alleviates paralysis if given after "family-contact" exposure; whether it prevents paralysis if given during an epidemic; and whether its influence of a few weeks' duration is enough to affect the epidemiology of poliomyelitis. Since gamma globulin has been given a fair trial and found wanting in protecting family contacts, as well as in preventing paralysis or influencing epidemics,[3] there should be little ground for continued enthusiasm for this method of bleeding part of the population for the dubious objective of postponing poliomyelitis in other parts for a month or two and at the cost of about $25,000 for each possible case postponed.
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> Two years ago the *Journal* summed up the case for gamma globulin as follows[4]: "In the relative calm of the off season one thing seems quite clear—that gamma globulin will not be the ultimate control measure against

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[1] Rusk, H. A.: Confusion over programs to combat polio justified. *New York Times*, March 14, 1954.

[2] American National Red Cross, Office of Public Information: 5,000,000 CCS. of gamma globulin provided by Red Cross in 1953. (News Release No. 2458-1253) 2 pp. Washington, D. C., 1954.

[3] National Advisory Committee for Evaluation of Gamma Globulin: Evaluation of gamma globulin in prophylaxis of paralytic poliomyelitis in 1953. J.A.M.A., 1954, **154,** 1086.

[4] Editorial: Gamma globulin in poliomyelitis prevention. New England J. Med., 1953, **248,** 786.

poliomyelitis"; a year later it was stressed[5] that "the history of measures used in the treatment and prophylaxis of poliomyelitis is full of conclusions based on inadequate material and subsequently proved to be erroneous." There is no reason why the difficulties and confusion should not be aired publicly.

Whether gamma globulin (immune globulin) is of "no value" may continue to be debated, but it is quite apparent that proof of its value has not been established. In the consideration of the use of gamma globulin the following points must be kept in mind:

1. It is obtained from the serum of donors having variable degrees of immunity to one or more strains of the poliomyelitis virus.
2. There is no evidence to indicate what dosage of gamma globulin might be effective in neutralizing in the body of a patient the virus of any of the strains.
3. Administration of gamma globulin to individuals in an area having poliomyelitis has not been epidemiologically established.
4. Duration of immunologic effect in the use of gamma globulin in any disease is estimated to be 4 to 6 weeks and so, in poliomyelitis as in other disease, this raises the pertinent question of repeat injections during any epidemic year.

Despite the questions noted above and the obvious failure in the past of gamma globulin to have any demonstrable value, a limited supply has been allocated to the District of Columbia and may be available after consultation with the Bureau of Disease Control of the D. C. Department of Public Health. (See June issue of MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA, page 333.) The consultation with the Department of Public Health will determine which individuals are to be given the injections, and what dosage is recommended, based upon this year's suggested increase which would bring the dosage up to 0.2 c.c. per pound of body weight. In an attempt to further evaluate the use of this serum, and since the Department of Public Health is charged with the responsibility of equitable distribution of the serum, physicians will be required to fill out detailed reports on all patients to whom it is administered.

GEORGE MAKSIM, M.D.
Chairman, Committee on Public Health,
The Medical Society of the District of
Columbia

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[5] Editorial: Poliomyelitis prevention and gamma globulin—reorientation. Ibid., 1953, **249**, 79.

To help fulfill the Bible's promise that "His children shall have a place of refuge," The House of Mercy opens its doors to

UNWED MOTHERS AND THEIR BABIES

To you, Doctor X, The House of Mercy offers an opportunity to put two lives on the right course at only the cost of a conversation or telephone call. Those two human beings are: an unwed mother-to-be, who might come to you or about whom you know, and the child she is to bring into the world.

The House of Mercy at Klingle Road and Rosemont Avenues, N.W., Washington, D.C., telephone Columbia 5-5229, invites everyone who needs its facilities to 'phone or to come directly. Complete confidence is understood.

Illegitimate births in and around the District of Columbia number some 500 to 600 a year, according to reliable estimates. The House of Mercy does not attempt to deal with the reasons that produce those statistics. But it does have a vital concern with the end results, that is, the mothers and their infants.

The House of Mercy wants to receive as many of those unwed mothers and their children as it can accommodate.

It is to help meet the Bible's promise that "His children shall have a place of refuge" that the House of Mercy has kept its doors open over the past 82 years. It has fulfilled the definition of mercy which Webster says is "compassionate treatment of the unfortunate."

This is a nonsectarian institution. Girls of all faiths are welcome. However, the House of Mercy does have strong Episcopal underpinnings: The Women's Auxiliary of the Episcopal Church of the Washington Diocese made the first move in what

The House of Mercy

eventually resulted in the House of Mercy; The Right Reverend Angus Dun, Bishop of Washington, is its President; and Deaconess Dieterly is the directress. The House of Mercy has its own chapel, always open, and regular services are held.

Unwed motherhood is an experience of shaking proportions at best; it can leave scars that never heal. But with proper care and guidance, a girl and her baby can be perfectly normal. She can face the world with faith in the future for her child and herself, and a resolve to be a useful member of society.

After an initial interview, a girl who comes to the House of Mercy is asked to make a small payment to defray the cost of her care. This is only a fraction of the total cost, however, and in needy cases no payment is required. The rest of the expense of running the institution comes from public donations, a phantom dinner, a cake and apron sale, and investments.

Once in the House of Mercy, a large, airy building overlooking Rock Creek Park, a girl finds she is treated with great professional care, with sympathy and understanding.

But perhaps equally important, she becomes a part of a group of 20 to 25 girls who either have had their babies or are about to, and in this atmosphere she is neither a patient nor a guest, but rather a person who is helping herself. Within the limits of physical condition, the girls help with the housework, the cooking, and the day-to-day operation of the House of Mercy. A highly skilled social worker is a permanent member of the staff. She is available for consultation whenever a girl wants her. There is time for recreation too; a charming, secluded garden complements the quiet recesses of the House of Mercy.

The finest medical and dental care is provided. Babies are delivered at a hospital, and about five days after the birth the mother and her infant are brought back to the House of Mercy. There are three nurseries for varying aged babies, and pediatricians from the panel of medical volunteers visit these nurseries once a week and are on call at all times. The mothers have the best possible medical and obstetrical care, both before and after the baby is born.

Each mother decides for herself whether to place her baby for adoption or to keep it. She is helped in her decision by the staff of the House of Mercy. If she decides in favor of adoption, the House of Mercy guides her through the arrangements with approved agencies for placing children.

The files of the House of Mercy are crammed with letters from girls who found it a refuge in time of great need; for many it was the difference between living today as normal humans and being relegated to some sort of secondary place in society.

Everyone who reads this article is a potential guide in directing someone to the House of Mercy. That can be a most satisfying evidence of humanity.

On the Lighter Side

On Thursday, May 13, 1954, 112 physician-members of the District of Columbia Medical Society, and their friends, teed off at the Kenwood Country Club in the annual Pfizer Physicians Golf Tournament.

The competition was spirited and zestful. The golf balls were zinging high and low as the foursomes eagerly began the 18 holes in anticipation of the exhilarating nineteenth hole.

Dr. William J. Evans fired a brilliant 76 to win top honors and the Tournament Trophy. Dr. Robert Coffey was one stroke off the pace with an accurate 77 and he received second honors. Third honors went to Dr. Leonard Berman with a commendable 80.

Other scores worthy of note were obtained by Dr. Edgar Quayle and Dr. Francis Joseph Crilley with an 81 each. Drs. Richard Meyer, Marshall Parks, and Benjamin Franklin Dean each fired a satisfactory 82. Drs. James Fitzgerald and Howard Parker each shot an 83, and Dr. John W. Nesbitt holed out in 84.

The most surprised golfer of the day was Dr. Maurice VanKinsbergen, who won the low net Trophy. The handicap knocked off enough strokes to give him a low net of 68. Second low net honors went to Drs. Dean and Parks, with a net of 71.

At the close of the tournament day, dinner was served the golfers and the guests in the Dogwood Room of the Club, followed by the presentation of trophies and the distribution of prizes.

The most remarkable thing about a golf tournament, from a personal viewpoint, is the enthusiasm shown by the participants for the game. No one will take any stroke for granted, and in some instances the bystanders must stop breathing while the competitor angles and ogles the ball prior to putting or driving. Postmortems were held over each hole and such words as eagles and birdies and bogies, roughs and traps and greens, and putts and putters and woods and irons were on everyone's lips at the nineteenth hole. One receives the impression that all the forces of evil were striving to keep that little white ball from rolling into the cup.

PERSONAL NOTE: Please let us reiterate and restate information that we gave to you in our initial effort. We know that there are many talented fellows in our Medical Society who have talent other than and apart from their medical ability. We would like to weave a few words around and about these talents, but we have not been able to pry loose the information that we want. Don't be bashful, fellows!!

Now that summer is upon us and the rivers and bay are cool and inviting we should be hearing from the boatmen, the yachtsman, and the pullers of the oar. Maybe there is someone with a musical or a theatrical background who would make good copy? Don't hide your talents under the bushel of bashfulness! Drop us a line, or, phone Executive 3-6258 and give to us your Lighter and—maybe—your brighter side.

FISHING NOTE: A recent catch of 80 pan-size spot and croakers were reported by Dr. Joseph M. Cocimano. The fish were hooked off the boat Miss Solomon, out of Solomon's Island harbor, chartered by the Meredyth Pharmaceutical Company for a day's outing. The bait used was bloodworms exclusively and even the toadfish and eels joined in the feast, according to Dr. Cocimano.

ACHIEVEMENT NOTE: Dr. J. Ross Veal was presented an achievement award at the Alabama Alumni annual banquet held at the Willard Hotel, May 21. Jeff Coleman, former Alabama University star athlete and coach of all sports, made the presentation.

CHUCKLE NOTE: Being married saves a man a lot of time making up his own mind.

J. EARL KADAN, M.D.

News and Personals

MEETINGS

The first **President's Night** since 1940 was observed on May 12. **Dr. Herbert P. Ramsey,** President of the Medical Society of the District of Columbia, showed a movie film he himself had produced entitled, "These I Have Seen," before a near-capacity audience in the Medical Society's auditorium. In showing the film, which was in color and black and white, Dr. Ramsey gave a running commentary on the medical scenes and medical personalities of yesterday; in sharp contrast were depicted many of Washington's medical buildings today, even some of those just in process of erection, such as Providence Hospital and the Washington Hospital Center.

Dr. Daniel L. Borden, Past President of the Medical Society and a long-time friend of Dr. Ramsey, presided. Dr. Walter Freeman, Chairman of the Executive Board, presented Dr. Ramsey with a gavel, inscribed to commemorate the year of his Presidency of the Society.

A choral group, made up of members of both the Medical Society and the Woman's Auxiliary, pleased the audience with a musical program, produced under the direction of Dr. Harry Douglas, who was also Chairman of the Committee for President's Night. Dr. Earle Thompson directed the chorus, and himself, an excellent baritone, sang several selections. Able accompanist at the piano was Dr. Maurice VanKinsbergen, who also delighted the audience with some special piano numbers.

Georgetown University School of Medicine was host on May 29 to an **Area Conference on the Teaching of Psychiatry** in the preclinical years. The schools represented at the Conference, in addition to Georgetown, were Johns Hopkins University, the University of Maryland, George Washington University, Howard University, Medical College of Virginia, and the University of Virginia. Co-chairmen for the meeting were Dr. George N. Raines, Professor and Director of the Department of Psychiatry at Georgetown, and Dr. Jacob E. Finesinger, who holds the same position as Dr. Raines at the University of Maryland.

The Section on Pathology and Laboratory Medicine elected new officers on May 21. They are:

Dr. James E. Ash, *Chairman;* Dr. Kenneth McCoy, *Vice Chairman;* Dr. Edward C. McGarry, *Secretary-Treasurer;* Dr. E. Clarence Rice, *Councillor.*

The Section on Radiology of the District of Columbia Medical Society elected the following officers at its May meeting:

Dr. Karl C Corley, *Chairman;* Dr. Francis C. Allman, *Vice Chairman;* Dr. John A. Long, *Secretary-Treasurer.*

The Section on General Practice held its last meeting until fall on May 18 in the Medical Society's Building. Dr. William T. Gibb, Assistant Clinical Professor of Medicine, George Washington University School of Medicine, was the guest speaker; his subject for discussion was "Psychosomatic Gastroenterology."

All officers of the Section were reëlected at the business session. They are:

Dr. I. Phillips Frohman, *Chairman;* Dr. Stewart Clapp, *Vice Chairman;* Dr. W. Robert Perkins, Jr., *Secretary-Treasurer.*

The Washington Medical and Surgical Society closed its 57th season with a banquet and dinner dance at the Hotel 2400, May 24. The **Frank E. Gibson Award,** which is given annually for the best paper presented during the year's program, was presented to **Dr. Ralph R. Stevenson** for his paper on "X-ray Findings in the 'Normal Female Pelvis.' " Presentation of certificate and cash prize was made by Dr. C. Willard Camalier, Jr., Chairman of the Awards Committee. Dr. Edward C. Wilson, Chairman of the Banquet Committee, arranged the dinner and program with the assistance of members of his committee.

The recipient of last year's Gibson Award was only recently reported to the ANNALS staff. He was **Dr. Alfred J. Suraci,** who was cited for his paper on "Problems and Accomplishments in Reconstructive Surgery." Dr. Raymond Fenton, Chairman of the Awards Committee for 1953, presented the award and certificate to Dr. Suraci.

Dr. John M. Orem is the retiring President of the Society. **Dr. Emil J. C. Hildenbrand** is the new incumbent and will serve during 1954–55.

The George Washington University Medical Society held its annual business meeting in the Medical Society's Building, May 19. **Dr. Luther H. Snyder,** retiring President, gave the President's Address on "Subversion in Medicine."

The following officers were elected to serve during 1954–55:

Dr. Robert R. Montgomery, *President-elect;* Dr. Richard H. Fischer, *First Vice President;* Dr. Donald H. Leeper, *Second Vice President;* Dr. William O. Bailey, Jr., *Secretary;* Dr. Naomi M. Kanof, *Treasurer;* Dr. Snyder, *Council member for 3 years.*

Dr. Leland C. Stevenson took office as the new President of the Society for the coming year.

The Jacobi Medical Society elected officers for the following year at a dinner meeting at the Washington Hotel, May 17. They are:

Dr. Charles G. Aronstein, *President;* Dr. Lawrence E. Putnam, *Vice President;* Dr. William Lewis, *Secretary;* and Dr. Armand Gordon, *Treasurer.*

GENERAL NEWS

The National Microbiological Institute, National Institutes of Health, announces that its **Laboratory of Clinical Investigation in the Clinical Center** will be hospitalizing this summer a **limited number of patients with poliomyelitis** for study and treatment. Major interest will be centered in the study of the first case occurring in a family with three or more children and in the study of the pregnant mother who develops poliomyelitis near term. Physicians who may wish to refer cases should call the office of Dr. Norman B. McCullough, National Institutes of Health, Oliver 4-1400, Extension 3141.

The Executive Board of the Medical Society of the District of Columbia held its regular session on Monday evening, May 24, with Dr. Walter Freeman, Chairman of the Board, presiding.

President-elect Preston A. McLendon submitted his committee appointments for 1954–55 for approval by the Board with the understanding that they would be confirmed later by the incoming Board. In view of the suggestion that a D. C. Physicians' Golf Association be organized, Dr. McLendon recommended that the Society's Sports Committee be discontinued, especially since golf has been the main activity of that committee. The Board concurred.

The Board confirmed the following appointments submitted by President Herbert P. Ramsey:

Drs. Robert U. Cooper and Paul Jaquet to serve as a Special Committee on Schools for Secretaries and Doctors' Assistants.

Dr. Hugh H. Hussey to represent the Medical Society as Counselor for the Georgetown University Chapter of the Student American Medical Association.

Dr. William H. Beard, Chairman, and Dr. Isadore Levin to act as a Special Committee for Liaison with the Federal Communications Commission.

Chairman Freeman designated Drs. Ramsey, McLendon, and Wallace M. Yater to meet with representatives of the Hospital Council to discuss the Hospital Service Agency and related problems.

The Board voted to support the position of the Graduate Nurses' Association with respect to the need for a law to license practical nurses and schools for practical nursing in the District of Columbia.

In accord with a recommendation of the House Committee that the old books, instruments and equipment now stored on the third floor of the Society's building be disposed of, the Board moved that such disposition be left to the discretion of the Secretary.

Dr. Albert H. Holland, Jr., Medical Director of the Food and Drug Administration, advises the Executive Offices of the Medical Society that the Administration is planning to increase its medical staff by approximately 4 or 5 members.

Two of these vacancies exist in the New Drug Branch, which is responsible for the review and approval of new drug applications which are submitted by industry prior to releasing the new drugs for general sale. The entrance salary for qualified applicants is $9,600.

The other openings are for physicians who would devote much of their time to the establishment of clinical studies with drugs which the Administration believes to be dangerous or fraudulent and preparing this information for use by the legal staff preparatory to court action. The beginning salary for qualified individuals may be either $8,360 or $9,600.

To assure the listing of all outstanding professional 16 mm. films, regardless of availability, in the forthcoming **Directory of Professional Motion Picture Films and Authors,** now being compiled, all film authors are urgently requested to immediately write for film questionnaires. Other members of the profession are asked to coöperate in this endeavor by forwarding this announcement to an author or by directly providing the film title and name and address of any film author to Professional Publications, Compilation Department, 2010 Kentucky Street, Lawrence, Kansas.

Although the information on nearly 4,275 films has been compiled, the number of useful films produced is unknown. To expedite the exchange of professional knowledge, C. D. Young, Director of Professional Publications, has asked that the above announcement be included in our journal.

Copies of "**Regulations for the Guidance of Physicians Engaged in Practice under the Workmen's Compensation Law with Appended Fee Schedule,**" adopted by the Medical Society of the district of Columbia in May, 1952, are available upon request in person or by telephone to the Society's Executive Offices, 1718 M Street, N.W., District 7-3111.

Formation of a **Federal Association for Epilepsy,** incorporated under the laws of Virginia, has been announced by its President, Mrs. Marvin T. Broyhill, Sr., of Arlington, Va. The new organization hopes to raise funds to start building a $250,000 school and treatment facility for young epileptics in this area within the next six months.

Other officers of the Association are Dr. Joseph W. Stein, of Arlington, Vice President, and Harold Babbitt, Secretary-Treasurer. The Board of Directors include the officers and Dr. and Mrs. Henry L. Bowditch, of Ruxton, Md.; Dr. Ralph D. Beachley, Health Director of Arlington County; Dr. W. C. Welburn, Medical Examiner for Arlington County; and Thomas E. Jenks, Washington attorney.

Dr. Walter A. Bloedorn, Dean of the School of Medicine, **George Washington University,** administered the Oath of Hippocrates to 78 members of the senior class in special **Precommencement Exercises** at the Medical Society's Building, June 8. Dr. Thomas McPherson Brown, Professor of Medicine, gave the principal address on "Preventative or Anticipatory Medicine."

The following class members received honorary awards:

Solomon Efrem Barr, the John Ordronaux Prize of $150, for the highest scholastic standing

Cornelius John Hayes, the Oscar Benwood Hunter Award in Pathology of $100, for demonstrating outstanding ability in pathology

Jean Robert Herdt, the Kane-King Obstetrical Society Prize of a journal subscription, for the outstanding thesis in obstetrics and gynecology

Messrs. Barr, Robert Dennis Bahr, Stephen William Dejter, Edward Carlton Swett, and Howard Erwin Ticktin, the Mosby Scholarship Book Awards, presented to the five class members with highest scholastic standing.

Dr. John A. Trautman, who has served as **Director of the Clinical Center** in Bethesda, Md., since 1951, has been assigned as Medical Officer in Charge of the Public Health Service Hospital in Fort Worth, Texas, a 1,000-bed institution which is devoted mainly to the treatment and study of psychiatric disorders and narcotics addiction. It was under Dr. Trautman's direction that the staff of the new research facility at Bethesda was assembled and the first study patients admitted in July, 1953.

Dr. Donald W. Patrick, who has been Medical Officer in charge of the PHS Hospital in Baltimore since 1949, has succeeded Dr. Trautman as Director.

Dr. Patrick was commissioned in the PHS in 1931 after receiving his medical degree from the University of Colorado.

PERSONALS

Dr. Howard T. Karsner, Research Advisor to the Surgeon General of the Navy, was honored by the National Board of Medical Examiners at its 1954 Annual Meeting in Philadelphia, May 2, which marked the final period of his membership on the Board. During his 24 years of service he has served as Chairman of its Examination Committee and as President. A scroll was presented to Dr. Karsner as an "expression of gratitude and appreciation. . . by his friends on the Board, for his leadership in the broad field of medical education." Dr. Karsner is an Associate member of the District Medical Society.

Dr. William T. Spence gave an illustrated lecture on "Cranioplasty Using Cranioplastic Resin" before the Harvey Cushing Neurosurgical Society at its meeting in Santa Fe, New Mexico, in May.

Dr. James W. Watts, Professor of Neurological Surgery, George Washington University School of Medicine, in company with Dr. Earl Walker, Professor of Neurosurgery, Johns Hopkins University, and Dr. Lothar Kalinowsky, of New York, left New York, July 3, via KLM airlines, for Europe, to visit various medical schools and medical centers in Germany. The visiting team is lecturing on neurosurgery and psychosurgery at Munich, Frankfort, Cologne, Heidelberg, Berlin, and Freiburg. The lecture tour is sponsored by the Unitarian Service Committee, Inc. of Boston. The physicians will return to the States on July 31.

DR. KELIHER HONORED BY GEORGETOWN UNIVERSITY

DR. THOMAS F. KELIHER (left) receiving the Georgetown University Bene Merenti Medal from the VERY REVEREND EDWARD B. BUNN, S.J., President of the University, at the Commencement exercises, June 7.

Dr. Thomas F. Keliher, Clinical Associate Professor of Medicine at Georgetown University School of Medicine, was selected to receive the Bene Merenti Medal at the University's 155th annual Commencement, June 7. This Georgetown medal of merit is awarded annually at the Commencement exercises in recognition of outstanding service to Georgetown.

Dr. Keliher, internist, received his medical degree from Georgetown in 1934 and became a member of the faculty shortly thereafter. He has held his present rank since 1945.

Ray H. Everett, who has retired as Executive Secretary of the District Social Hygiene Society, was honored for his 21 years of service at a testimonial dinner at the Sheraton Park Hotel, May 19. A silver tray was presented to him by his Washington friends and associates to commemorate the occasion. An honorary life membership in the American Social Hygiene Society was awarded to him "in grateful recognition of his fruitful labors for public health and family stability."

Among those who were present to speak for their organizations in appreciation of his work over many years in the field of social hygiene were Dr. Otis L. Anderson, Assistant Surgeon General of Public Health Service; Dr. S. Ross Taggart, representing Dr. Daniel L. Seckinger, D. C. Director of Public Health; Allan Johnson, representing the New York Social Hygiene Society; Dr. William P. Herbst, President of the District Social Hygiene Society; Dr. Frank Jones, Chief of the Department of Neurology, Howard University; and Theodore Wiprud, Secretary of the District Medical Society.

B. M. McKelway, Editor of *The Star,* was master of ceremonies. In addition to his own words of praise of Mr. Everett, he read messages of tribute from prominent persons who could not attend.

Dr. Zigmond M. Lebensohn addressed the Wyoming State Medical Society at its annual meeting in Sheridan, June 8. The subject of his address was "The Psychiatric Half of General Practice." Dr. Lebensohn was also the dinner speaker at the Society's annual banquet.

Dr. James J. Feffer was one of the guest speakers who assisted the staff of the Trudeau School of Tuberculosis in presenting its 40th annual session at Saranac Lake, New York. The four-week course, which ended on June 25, was attended by 36 doctors from 13 states and 6 foreign countries.

CALENDAR OF SPEAKERS

The following members of the Medical Society of the District of Columbia have addressed lay groups during the past several weeks. The Society maintains a Speakers Bureau, sponsored by the Committee on Public Relations, through which requests for speakers for lay groups, including radio programs, can be filled.

Date	*Speaker*	*Subject or Title*	*Organization*
April 26	Dr. Anthony Zappala	Alcoholism	Cosmopolitan Group of Alcoholics Anonymous
May 14	Dr. Winfred Overholser	Book Review, "The Psychiatrist and the Law"	George Washington University Faculty Women's Club
May 17	Dr. C. Albert Hudson Dr. James M. Moss	Obesity	Health Forum sponsored by Alexandria Medical Society
May 18	Dr. Edith H. Weigert	The Personal Factors in Marital Adjustments	Workshop on Marriage, Jewish Community Center, Bethesda, Md.
May 20	Dr. Leslie V. Dill Dr. John R. Cavanagh	Sex for Parents	Southeast Family Conference
May 20	Dr. Winfred Overholser	Mental Illness—The Score	Georgetown Forum over WTTG-TV
May 23	Dr. Marshall deG. Ruffin	Psychosomatic Conditions	Radio panel discussion over WWDC, sponsored by Junior Bar Section, D.C. Bar Association
May 25	Dr. Robert B. Hightower Dr. Richard E. Palmer Dr. Forrest M. Swisher	Poliomyelitis	Health Forum sponsored by Alexandria Medical Society
June 1	Dr. Louis Goldstein	Anatomy, Physiology and Hygiene of the Female	Women's Club of Washington Highlands Jewish Center

Dr. J. Ross Veal, Chairman of the Public Health Committee of the Washington Board of Trade, advises the Secretary of the Medical Society that **Dr. Oscar B. Hunter, Jr.,** has been appointed chairman of a special subcommittee to study the merit and feasibility of erecting a hospital for persons with chronic illnesses which would be self-sustaining.

Dr. Henry A. Monat left by plane, June 27, to attend the Third International Gerontological Congress in London, where he was invited to speak, July 20, on "Nutrition in Aged Cardiacs." Dr. Monat is a member of the Nutrition Society of Great Britain. He will return by plane on July 27.

Dr. J. Ross Veal was reëlected Chairman of the **Health Section of the United Community Services** at its meeting, May 27. Dr. George Maksim, Chairman of the Medical Society's Committee on Public Health, was elected to the Executive Committee; reëlected to the Committee were Drs. Paul B. Cornely, E. H. Cushing, Joseph W. Leverenz and Alice M. Waterhouse, and Daniel L. Seckinger, ex officio member.

Drs. Joseph J. Buchanan and Howard M. Payne were reëlected delegates to the UCS Board of Trustees.

Among those reëlected to represent the public at large were Dr. Charlotte P. Donlan and Dr. Frederick D. Mott.

Dr. Jed W. Pearson, Jr. participated in a discussion group on "Education for Marriage" during the 34th Annual Meeting of the Planned Parenthood Federation of America, which was held at the Waldorf-Astoria, New York, May 6.

Dr. Robert P. Odenwald was the annual guest lecturer of the Laennec Society of the Medical College of Virginia in Richmond, April 23. He spoke on the subject, "The Psychiatrist and the Clergyman."

Dr. Willard P. McNeill, who has been taking a two-year residency in surgery at Bryn Mawr Hospital, Bryn Mawr, Penna., returned to Washington in June. He is residing at 8107 Roanoke Avenue, Takoma Park 12, D. C.

Dr. Milton C. Cobey was a guest of the Association of Bone and Joint Surgeons at its meeting in Augusta, Georgia, April 2 and 3.

Dr. William H. Hanna, formerly of the Yater Clinic, has moved to Elgin, Illinois; his address is 102 West Spring Street.

Robert O. Warthen, who has completed 17 months' service as Chief of Pediatrics at Chanute Air Force Base Hospital in Rantoul, Illinois, has returned to Washington and reopened his office for the practice of pediatrics at 3716 Howard Avenue, Kensington, Md.

Friends of **Dr. Harry A. Fowler,** Life member of the District Medical Society, may call on him or address him at Emergency Hospital, where he is now residing as a permanent and distinguished house guest. Dr. Fowler headed the urology department at Emergency until he retired in 1948. It is reported that he likes his new home, where he is surrounded by people with whom he worked for many, many years.

Dr. James L. Kelley, Jr., is practicing surgery in San Diego, California, where he is associated with Drs. A. E. Moore and John H. Steelquist at 2120 Fourth Street.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, May 24, 1954, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society.

Active Members

James Edward Boland, 337 Irvington Street
Gerald Perman, 2430 Pennsylvania Avenue, N.W.
Richard Kemp, 1801 Eye Street, N.W.
Riley F. Thomas, 1326 Girard Street, N.W.

Associate Members

Henry G. Bullwinkel, King George, Virginia
William Boyd Looney, U. S. Naval Hospital, Bethesda, Md.

Resident-Intern Members

James K. Gordon, 2109 N. Scott Street, Arlington, Va.
Dean H. Martin, 2333 Huidekoper Place, N.W.

Resigned
Active

Christopher T. Bever
William K. Billingsley
Catherine Blumberg
Norman Q. Brill
Peter Paul Brue
Lewis M. Burdette
Nicholas J. Cotsonas, Jr.
J. DeWitt Fox
T. Wiley Hodges
Lorman L. Hoopes
Charles P. Howze
Robert Hunter
Richard L. Jackson
James M. Moser, Jr.
William E. Nessell
Herbert Wanderman
Prentiss Willson, Jr.

Resigned
Associate

Joe M. Blumberg
Kenneth E. Blundon
William D. Chase
V. L. Ellicott
William Frank
Dorothy Gill
Camp S. Huntington
Seruch T. Kimble
Raymond W. Murray
Jocelyn R. Neufeld
John B. Ross
Russell M. Wilder
Frank A. Zack

BOOK REVIEWS

Narcotics and Narcotic Addiction. David W. Maurer, Ph.D., Professor of English and the Humanities, University of Louisville; Lecturer on Narcotic Addiction and Criminal Argots, Southern Police Institute, Louisville, Kentucky, and Victor H. Vogel, M.D., Medical Officer in Charge, European Activities, U. S. Public Health Service, Paris, France; Formerly, Medical Officer in Charge, U. S. Public Health Service Hospital, Lexington, Kentucky. Price, $7.50. Pp. 303. Springfield, Ill.: Thomas, 1954.

This book was written for government officials and law enforcement officers, but the material can be well utilized by the physician as a reference to general knowledge of addiction.

It describes the varied methods of administration used by addicts and illustrates many of the implements.

Of further interest is a discussion of the various phases of treatment in addiction, with reference to clinical and research work done at the Lexington Hospital.

The argot of the narcotic addict is included in a surprisingly long glossary which provides derivations of the words completely foreign to all but the professional addict.

Methods of testing and the pharmacology of the addicting drugs are well outlined.

In view of more recent trends toward addiction, especially in the younger age groups, this book serves as a helpful guide to the physician in better understanding this disease.

James G. Shea, M.D.

Music Therapy. Edited by Edward Podolsky, M.D., Department of Psychiatry, Kings County Hospital, Brooklyn, N. Y. Price, $6.00. Pp. 335. New York: Philosophical Library, 1954.

Ever since the days when David tried (not too successfully!) to allay the "evil spirit" of King Saul by playing the harp, interest has been expressed in the possibilities of music in the treatment of the mentally ill. Dr. Maurice Friedman (Annals, 1953, **22,** 421) recently gave readers of this journal an interesting review of some aspects of this form of therapy. Music, as having the most direct emotional appeal of all forms of expression, is perhaps for that reason the least susceptible to having its effects rigidly analyzed, and a share, certainly, of what has been written about its use as a therapeutic agent falls within the realm of the speculative and hypothetical.

Dr. Podolsky, himself a psychiatrist, has assembled here a good selection (32 articles) of the literature on the topic as it has appeared in various periodicals—psychiatric, psychological, musical, and those devoted to occupational therapy.

Dr. Ira Altshuler, who has done much in this field, contributes two papers. He proposes a "homeopathic" theory, that is, the selection of music to accord with the mood of the patient, at least initially, to be followed later by modifications of mood, volume and rhythm.

Miss Frances Paperte presents a report of the program which she supervised at Walter Reed General Hospital a few years ago, while Pepinsky very properly urges a sounder design in planning experiments having to do with music in therapy. Howard Hanson, the eminent composer, contributes an article on Some Objective Studies of Rhythm in Music.

Other articles deal with the application of music to the treatment of specific conditions, including heart disease, athetotic tremors, and tension headaches.

Enthusiasm in therapeutic or other research is praiseworthy, but it does sometimes tend to cloud the critical judgment. That truth is exemplified in some of the essays in the present volume. The old logical fallacy of *post hoc, propter hoc* must always be guarded against!

The use of music in therapy certainly has possibilities, and is deserving of further study. In the meantime, Dr. Podolsky has presented some interesting and stimulating data.

Winfred Overholser, M.D.

Salt and the Heart. Edward T. Yorke, M.D., Attending Cardiologist, Alexian Brothers Hospital; Associate Cardiologist, St. Elizabeth Hospital; Dispensary Physician, Elizabeth General Hospital, Elizabeth, N. J.; Consultant in Medicine, Rahway Hospital, Rahway, N. J. Price, $3.75. Pp. 83. Linden, N. J.: Drapkin Books, 1953.

There is no doubt that one of the chief reasons for failure of many patients to adhere to a low sodium diet is lack of proper understanding of the diet's purpose. We have all had the experience of discovering that one of our patients on a "low salt" diet is taking bicarbonate of soda or some such preparation with impunity because he did not understand that sodium was the culprit and not "salt" per se.

This short book is an effort to delineate for the more inquisitive and intelligent patient why salt is restricted in heart failure and to discuss why certain classes of foods are acceptable or forbidden on diets of varying rigidness. He discusses foods as groups, pointing out what sodium content they have in the natural state and what changes in the content are incidental or necessary in their processing.

Because of its brevity this book is necessarily sketchy in its portrayal of the role of sodium in various metabolic derangements and disease states. Its tips on diets are helpful but limited.

In all, it is an attempt in the right direction, that is, to give the cardiac patient a better understanding of the purpose of salt restriction and some methods available to make his diet palatable in the face of such restriction.

James Leonard, M.D.

BOOKS RECEIVED

Acknowledgement is made of the following books which have recently been received. Selections will be made for more extensive review in the interest of our readers and as space permits. Physicians are urged to submit reviews of additional current books which, in their opinion, merit comment.

The Atom Story—Being the Story of the Atom and the Human Race. J. G. Feinberg, M.Sc., with illustrations by Lewis and a foreword by Frederick Soddy, F.R.S. Price, $4.75. Pp. 243. New York: Philosophical Library, 1953.

Fifty Years of Medicine. Lord Horder, G.C.V.O., M.D., F.R.C.P. Price, $2.50. Pp. 70. New York: Philosophical Library, 1954.

You and Your Health. Edwin P. Jordan, M.D., Executive Director, American Association of Medical Clinics. Price, $3.95. Pp. 296. New York: Putnam, 1954.

Illustrated Review of Fracture Treatment. Frederick Lee Liebolt, A.B., M.D., Sc.D., LL.D., Attending Surgeon in Charge of Orthopedics, the New York Hospital; Attending Orthopedic Surgeon, Hospital for Special Surgery; Associate Professor of Clinical Surgery (Orthopedics), Cornell University Medical College. Price, paper, $4.00. Pp. 229. Los Altos, California: Lange Medical Publishers, 1954.

Narcotics and Narcotic Addiction. David W. Maurer, Ph.D., Professor of English and the Humanities, University of Louisville; Lecturer on Narcotic Addiction and Criminal Argots, Southern Police Institute, Louisville, Kentucky, and Victor H. Vogel, M.D., Medical Officer in Charge, European Activities, U. S. Public Health Service, Paris, France; formerly, Medical Officer in Charge, U. S. Public Health Service Hospital, Lexington, Kentucky. Price, $7.50. Pp. 303. Springfield, Ill.: Thomas, 1954.

Understanding the Japanese Mind. James Clark Moloney, M.D. Price, $3.50. Pp. 252. New York: Philosophical Library, 1954.

The Jealous Child. Edward Podolsky, M.D., Department of Psychiatry, Kings County Hospital, Brooklyn, New York. Price, $3.75. Pp. 147. New York: Philosophical Library, 1954.

Music Therapy. Edited by Edward Podolsky, M.D., Department of Psychiatry, Kings County Hospital, Brooklyn, New York. Price, $6.00. Pp. 335. New York: Philosophical Library, 1954.

The Allergic Child. Harry Swartz, M.D. Price, $3.95. Pp. 297. New York: Coward-McCann, 1954.

FREDERICK YATES, M.D., LL.B., LL.M.

(1877–1954)

Dr. Frederick Yates, general practitioner, a Life member of the Medical Society of the District of Columbia, died, May 27, 1954, at Emergency Hospital following a brief illness.

Dr. Yates was born in Manchester, England, December 21, 1877, and came to this country with his parents, Thomas and Ellen Scofield Yates, in

1885. He received his early education in the public schools of the District of Columbia, graduating from Eastern High School in 1894. In 1904 he received his medical degree from George Washington University. He also held the degree of Bachelor of Laws and Master of Laws from National University. Following graduation from Medical School he interned at George Washington Hospital and took a course in postgraduate study at New York Postgraduate Hospital.

Dr. Yates had practiced in Washington for 50 years, from 1904 until 10 days before his death. His office was at 1008 M Street, N.W. He lived at 2343 Ashmead Place, N.W.

He became a member of both the Medical Association and the Medical Society of the District of Columbia in 1906. He was a member of the American Medical Association and the George Washington University Medical Society. Fraternal organizations with which he was affiliated included the Elks Club, Knights of Pythias, B.B. French Masonic Lodge, Columbia Commandery No. 2, and Almas Temple Shrine.

Survivors are his wife, Mrs. Lou E. Neil Yates; two sons, Commander Frederick A. Yates, U.S.N., Vienna, Va., and George Thomas Yates, a law student at the University of Denver; a daughter, Mrs. Adrian DeKoning, Denver, Colo.; a stepson, Andrew Archer, St. Petersburg, Fla., and a stepdaughter, Mrs. Lawrence J. Blackmar, of the home address.

Home and Office Blood Pressure Recordings—Freis

(*Continued from page 367*)

3. Keith, N. M., Wagener, H. P., and Barker, N. W.: Some different types of essential hypertension: their course and prognosis. Am. J. M. Sc., 1939, **197**, 332.
4. Smirk, F. H., and Alstad, K. S.: Treatment of arterial hypertension by penta- and hexamethonium salts based on 150 tests on hypertensives of varied etiology and 53 patients treated for periods of 2 to 14 months. Brit. M. J., 1951, **1**, 1217.
5. Moe, G. K.: Potentiation of pressor action of epinephrine by tetraethylammonium. J.A.M.A., 1948, **137**, 1115.
6. Freis, E. D., MacKay, J. C., and Oliver, W. F.: Effect of "sympatholytic" drugs on cardiovascular responses to epinephrine and norepinephrine in man. Circulation, 1951, **3**, 254.
7. Smirk, F. H.: Results of methonium treatment of hypertensive patients. Brit. M. J., 1954, **1**, 717.
8. Schroeder, H. A.: Hypertension; method of treatment, in Conn, H. F., editor: 1954 Current Therapy. Philadelphia: Saunders, 1954.

Paranoid State from Isoniazid—Weiss and Salzman

(*Continued from page 378*)

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2. Fetterhoff, K. I., Holmes, C. N., and Martin, G. E.: Hazards of isoniazid therapy in epileptics; report of one case. Ibid., 1952, **66**, 501.
3. O'Connor, J. B., Howlett, K. S., Jr., and Wagner, R. R.: Side effects accompanying use of iproniazid. Ibid., 1953, **68**, 270.
4. Lubing, H. N.: Peripheral neuropathy in tuberculous patients treated with isoniazid. Ibid., 1953, **68**, 458.
5. Salzman, L.: Resolution of a paranoid psychosis. M. Ann. District of Columbia, 1952, **21**, 489.

Fear and Phobias—Laughlin

(*Continued from page 391*)

tained despite the fact that it is neurotic and paradoxically achieves self-defeat, handicap, and a net loss. The *extension* or *generalization* of a phobia to include related areas is not well illustrated here. By this possible *progression* a phobia may come to include related, associated, or adjacent areas; for example, a phobia of bridges may come to include tall buildings, airplanes, mountains, or any high place. An understanding of this summary indicates the understanding of a major segment of the basic dynamics of phobias.*

(*To be continued*)

6800 Hillcrest Place
Chevy Chase 15, Md.

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* In supplement to our understanding of dynamics in the present state of psychoanalytic knowledge, I might offer a possible hypothesis to the ultimate origin of every phobia in the oral conflict. In accord with this view, the Oedipus situation may later reinforce, underline, repeat or distort earlier primordial oral patterns. Thus the dread and fear of the phobic object would represent not only the feared retaliation implicit to the Oedipus complex but on a deeper level would ultimately represent something further back. On the level of oral conflict it would equate the danger of the magical destruction of the loved and vitally needed maternal object of dependency. This would be a dreaded consequence to the hostility and rage of the infantile helplessness which follows the frustration of denial or unsatisfactory fulfillment.

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

1954–1955

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MICROCOCCAL (STAPHYLOCOCCAL) ENTEROCOLITIS: THERAPEUTIC CONSIDERATIONS

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THE occurrence of fatal micrococcal enterocolitis after the oral use of streptomycin was described in 1948 by Kramer.[1] Zischka,[2] in 1950, reported that this also may occur after the oral use of sulfaguanidine. In 1951 a report by Jackson and his associates[3] included the cases of 3 patients who, before death, had received a tetracycline compound. Severe diarrhea had developed and cultures of the stools disclosed the presence of *Micrococcus pyogenes*. Janbon and co-workers[4, 5] in 1952 reported 9 cases of severe diarrhea among patients receiving a tetracycline compound; they noted the presence of micrococci in the stools of victims of this "choleriformic syndrome." In the same year Haight and Finland,[6] Bernhart[7] and Meier[8] also reported cases in which the patients' use of a tetracycline compound had been associated with micrococci that were isolated from diarrheal stools.

The initial report of Kramer[1] attested to the lethal propensities of micrococcal enterocolitis. Meier[8] emphasized that the patient suffering circulatory collapse after operation should be suspected of having the disease. Haight and Finland[6] pointed out that recovery occurred after administration of erythromycin.

Several reports of our experiences with micrococcal enterocolitis have emanated from the Mayo Clinic.[9-13]

PATHOGENESIS

Most of the intestinal bacteria belong to the *Escherichia coli* and *Aerobacter aerogenes* groups, together with groups represented by Bacteroides, Clostridium and Proteus. In lesser numbers are found Pseudomonas, yeasts and enterococci. Micrococci may be present in the feces under normal conditions but seldom are seen in large numbers. Thus isolation of micrococci from the stools does not always indicate the presence of enterocolitis.

Ordinarily the paucity of micrococci in the gut is probably accounted for by their relative fastidiousness and their inability to compete with the hardier gram-negative bacteria. When antibacterial agents of broad spectrum are given, the number of *Escherichia coli* rapidly decreases, and by the fourth day of such therapy practically none are present. When the normal bacterial flora of the intestinal tract is inhibited or removed by such antibacterial agents, strains of *M. pyogenes* that are resistant to these compounds may then proliferate in the intestine. As a result of toxins produced by the micrococci growing in great numbers gastrointestinal and systemic symptoms are produced. The micrococci will persist unless removed by antibacterial agents to which they are susceptible, or until they are replaced by normal intestinal flora.

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* The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

Needham and Nichols[14] have demonstrated that more than a third of the micrococci present in the nasal passages of hospital personnel studied at the Mayo Clinic were resistant to streptomycin and compounds of the tetracycline group. It would now appear that some members of the hospital personnel normally harbor strains of *M. pyogenes* that are resistant to all the commonly employed antibiotics. Numerous other investigators, including Rountree and associates[15] and Barber and co-workers,[16] also have found nasal carriers of resistant micrococci among hospital personnel and other presumably healthy adults. Dowling and his group[17] found that in a group of patients in whom staphylococci were found to be present in cultures from the nose and throat, 74 per cent of cultures were still positive at the time the patients were dismissed from the hospital. Vogelsang and Böe[18] found that many members of a hospital staff were harboring penicillin-resistant pathogenic staphylococci in their upper respiratory tracts. They swabbed the throats of patients on their entrance to and dismissal from the hospital and found 18 per cent and 42 per cent respectively positive for penicillin-resistant staphylococci. Likewise, it has been demonstrated that victims of micrococcal enterocolitis may harbor resistant strains of *M. pyogenes* in their throats.[9]

These facts suggest that the resistant organisms are transferred from the upper part of the respiratory tract of one patient to that of another in the hospital, or from hospital personnel to patients. If a person harbors these resistant strains of micrococci in the upper part of the respiratory tract, it is theoretically possible for these micrococci to pass into the intestinal tract.

Although it is true that in the majority of cases this condition occurs postoperatively, it should be emphasized that it can occur among patients hospitalized for other reasons. At times the disease may be extremely severe in patients who are already ill from some disease such as pneumonia or peritonitis and who have not had an operation.[10, 11, 12] It seems reasonable to assume that the stress of a major surgical procedure, with the probable release of large amounts of adrenocortical hormones, may in some way increase the susceptibility of the patient to invasion by micrococci.

While the incidence of the complication is higher in patients receiving antibacterial agents by the oral route, it also occurs in patients receiving such agents parenterally.[10, 11, 12]

Clinical Aspects

The signs and symptoms of micrococcal enterocolitis are those of an intoxication, and identical with those ascribed to "staphylococcal food poisoning." In both conditions the bacterial toxins are directly responsible for the symptomatology; the clinical picture is that of intoxication rather than infection. Diarrhea, although not always present, is the usual herald of the complication. This may be mild, moderate, or extremely severe, with copious, liquid, greenish stools. Such stools are usually odorless because the antibacterial agent which has made the complication possible has eliminated the spore-forming bacteria, Clostridium and Bacteroides. Fever is usually present and is correlated with the severity of the systemic reactions. Anorexia is present initially, and nausea, vomiting and distention are frequently present. Varying grades of shock may appear, and not uncommonly shock is the presenting sign. Although excessive fatigue and exhaustion are common, a few patients exhibit marked restlessness. Mental confusion is noted occasionally. Falling blood pressure may initiate anuria.

DIAGNOSIS

When diarrhea develops in a seriously ill patient, and especially one who has recently undergone surgical measures, the presence of micrococcal enterocolitis should be suspected. If it is known that the patient has been receiving a predisposing antibacterial agent, the suspicion is strengthened. In such an instance, administration of the antibacterial agent should be stopped immediately and both smears and cultures made from the stools. The presence of innumerable gram-positive cocci in the smears is practically diagnostic of micrococcal enterocolitis. In severe cases the cocci are present nearly in pure culture in the stool.

If patients have received predisposing antibacterial agents in preparation for operations on the bowel, cultures of intestinal contents should be obtained at the time of operation to be sure that micrococci are not present in significant numbers. If such organisms are found at operation, an antibiotic agent to which the bacteria probably are sensitive is administered promptly after the surgical procedure.

TREATMENT

The type of treatment undertaken depends on the patient's condition and the relative numbers of micrococci isolated. Just as in the prophylactic procedure described in the foregoing paragraph, so when the smears reveal the presence of micrococci and the patient is gravely ill, prompt use of an antibiotic to which the micrococci probably are sensitive is indicated. For patients who are not gravely ill, to discontinue use of the offending antibacterial agent may be all that is necessary. The diarrhea and systemic symptoms may subside with time and symptomatic measures. Merely to stop administration of the offending antibacterial agent may be an insufficient remedy for seriously ill patients, however.

Until recently when micrococci were almost universally sensitive to erythromycin, that agent was the bulwark of antibiotic therapy. However, recent studies[13] have demonstrated that 7 of 100 strains of micrococci tested at the clinic were resistant to erythromycin. It has become apparent that erythromycin is no longer an automatically prescribed panacea for micrococcal enterocolitis. Thus, we[13] have found it necessary to use other antibiotics, such as bacitracin, chloramphenicol, neomycin and polymyxin, in attempts to combat the syndrome. Carbomycin is of no avail in infections owing to erythromycin-resistant micrococci because of its almost universal cross-resistance with erythromycin. Since bacitracin, neomycin and polymyxin are not absorbed from the intestinal tract, their intrinsic toxicity is avoided by oral administration. While chloramphenicol frequently exhibits cross-resistance with members of the tetracycline group of compounds against many bacteria, fortunately this is not true in the case of micrococci. Since chloramphenicol has been rarely used in the hospitals in Rochester, resistance to its action is slight.[14] Despite the ordinarily forbidding toxicity of chloramphenicol, this agent has rare application in this potentially fatal syndrome. The objection that use of such antibiotics as neomycin and polymyxin might delay the return of the normal flora seems minor if the situation is serious. Gramacidin and tyrothrycin are other agents which may be effective in treating erythromycin-resistant strains of micrococci responsible for enterocolitis.

We do not advocate parenteral administration of antibiotics in the treatment for micrococcal enterocolitis. If the patient is vomiting it may be difficult to avoid this type of administration. For the patient who has difficulty accepting the agent orally it frequently can be introduced through a gastric tube. If the tube is connected with a suction apparatus, the tube should be clamped for 2 hours to allow absorption of the antibiotic.

Although this form of enterocolitis may be severe, it should rarely, if ever, be fatal, if proper treatment is given. Its management is relatively simple, but the possibility of its occurrence must be kept in mind. Definitive therapy should result in clinical improvement within 24 to 72 hours and cultures of the stools should reveal a return to the usual intestinal flora.

Comment

We have been very successful to date in the management of micrococcal enterocolitis,[10-13] but with the emergence of erythromycin-resistant strains of micrococci[13] the future is somewhat shadowed. We fear that future instances of the syndrome may require dexterous manipulation of the antibiotics to which these micrococci remain sensitive. A sufficient number of such antibiotics exist if one is aware of their application.

Originally it was hoped that a preparation of oxytetracycline (terramycin)[12] which could be administered parenterally might decrease the incidence of enterocolitis which has complicated oral treatment with oxytetracycline and other agents. Since the incidence of the syndrome is higher when predisposing agents are given by the oral route than otherwise, this hope seemed to have some basis in fact. However, there have been at least 5 instances of micrococcal ileocolitis complicating intramuscular use of the new preparation,[13] although in 4 of these dihydrostreptomycin was used concurrently. A larger series of patients than we have treated to date will be required to determine whether the incidence of this complication is lower among patients who receive preparations parenterally than among those who are given predisposing antibiotics by the oral route.

Further experience will be required to answer more definitely the question of the relationship between pseudomembranous ileocolitis and micrococcal enterocolitis. Since both entities have the same clinical and histologic characteristics, the only possible distinguishing characteristics are bacteriologic. Like micrococcal enterocolitis, pseudomembranous ileocolitis has been observed at the Clinic among patients who have not undergone abdominal operations as well as among those who have.[19] At the time of this study we would limit the term "pseudomembranous ileocolitis" to those cases in which the symptomatology we have described is present but studies of the stools and intestines fail to reveal micrococci. Necropsy reports at the Clinic show that from 1927 to 1936, inclusive, when antibiotic agents were not available, 42 patients died of pseudomembranous ileocolitis, while from 1943 to 1952, inclusive, during the era of antibiotics, 37 patients died of pseudomembranous enterocolitis.[9] These data suggest that if micrococcal ileocolitis and pseudomembranous ileocolitis were one and the same thing, it would be necessary to indicate etiologic factors other than the antibacterial agents.

We emphasize again that antibiotic agents should be used only when they are specifically indicated and that they should not be used promiscuously for the treatment of minor illnesses. This applies not only to the antibacterial agents, use of which may make a patient susceptible to micrococcal enterocolitis, but also to the antibacterial agents capable of subduing the micrococci after development of the complication. In localities in which strains of *M. pyogenes* resistant to the predisposing antibacterial agents do not exist, micrococcal enterocolitis will not occur.

Summary and Conclusion

If, for any reason, a sulfonamide drug, streptomycin, or members of the tetracycline group of compounds—that is, chlortetracycline (aureomycin), oxytetracycline (terramycin) and tetracycline (achromycin or tetracyn)—is used, micrococcal enterocolitis may supervene. The condition may arise when the normal intestinal flora has been suppressed by the foregoing

(*Continued on page 473*)

ETIOLOGY OF SO-CALLED PULMONARY TUBERCULOMA*

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TWO groups of thoracic surgeons from the Washington area were among the first to report their relatively large surgical experience with solitary lung tumors.[1, 2] It is especially fitting, therefore, that one of the lesions which most frequently is responsible for the roentgenographic appearance of a solitary intrapulmonary tumor should be a subject for discussion among this group of pathologists. I am, of course, referring to the so-called tuberculoma of the lung. Although its structural characteristics are familiar to surgeons and pathologists, I wish to review briefly the salient macroscopic and microscopic features which distinguish this particular lesion from other pulmonary granulomas.

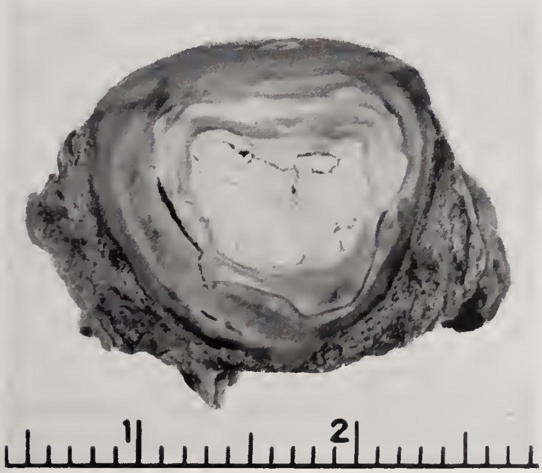

FIG. 1. Typical "tuberculoma" as seen in a surgical specimen. A hyaline pleural plaque covers the granuloma which is sharply demarcated from the adjacent normal lung parenchyma. A zone of laminated fibrous connective tissue surrounds the central caseous area. The etiology of this lesion was not determined since all special stains of multiple sections were negative. (AFIP Acc. 192558)

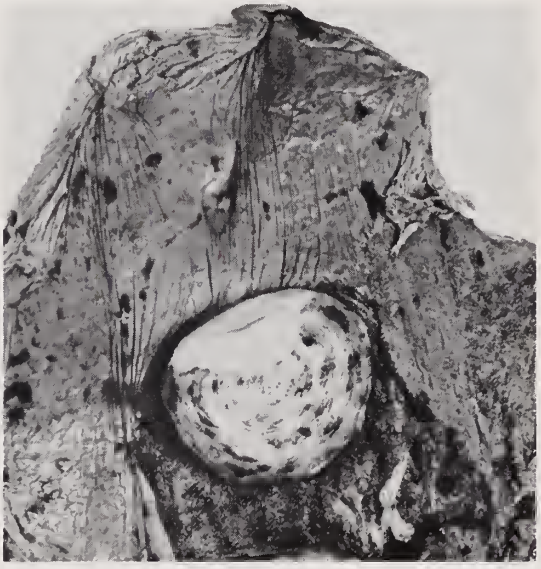

FIG. 2. Pulmonary granuloma near apex of right lower lobe presenting typical gross appearance of a "mature tuberculoma." Organisms identified as Histoplasma were demonstrated in this lesion. A well developed cone of hyaline extends into the center of the lesion from the pleural surface. (AFIP Acc. 194007)

The so-called tuberculoma that is the subject of this study is, in all essentials, identical with the lesions that have been described by Mahon and Forsee,[3] and Black and Ackerman.[4] The typical tuberculoma is a discrete, firm to hard, spheroidal mass located just beneath the pleura in the lung periphery (figure 1). As seen in the surgical specimen, the lesion usually measures from 1 to 3 cm. in diameter and is well en-

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[*] Presented at the annual joint meeting of the Baltimore and Washington Societies of Pathology and the Middle Eastern Region of the College of American Pathologists in Baltimore, May 8, 1954.

capsulated by dense fibrous connective tissue. At the pleural surface there is a tangential plaque of hyalinized scar tissue. Part of this thickening is external to the pleural elastic membrane and may represent a sort of callus.

as suggested by Black and Ackerman. It is also true, however, that a wedge or cone of hyalin extends into the center of the granuloma from the pleural surface (figure 2) as described by Mahon and Forsee. The cut surface may be homogeneous, but frequently there is a laminated pattern which may be exaggerated by concentric deposits of lime salts, Liesegang's rings (figure 2). Those lesions having a homogeneous appearance are likely to be soft and semidiffluent (figure 3). Mahon and Forsee have called them "unripe" tuberculomas. The others with a laminated surface are dry, granular, or chalky and

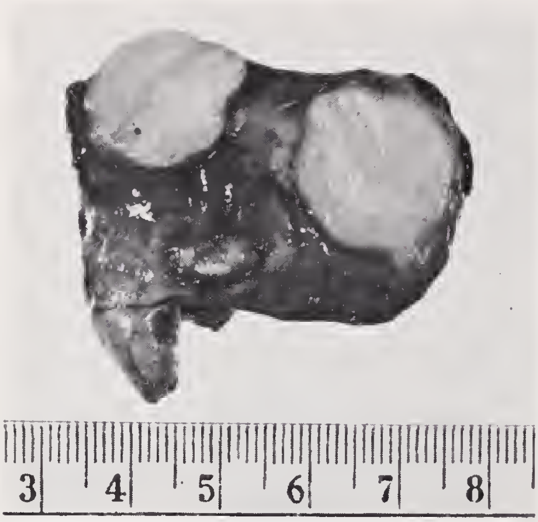

Fig. 3. Pulmonary granuloma due to Histoplasma. This lesion from the left lower lobe has the appearance of an "unripe tuberculoma." The homogeneous cut surface is elevated above the adjacent normal lung. This is considered a stage earlier than those represented in figures 1 and 2. (AFIP Acc. 568715)

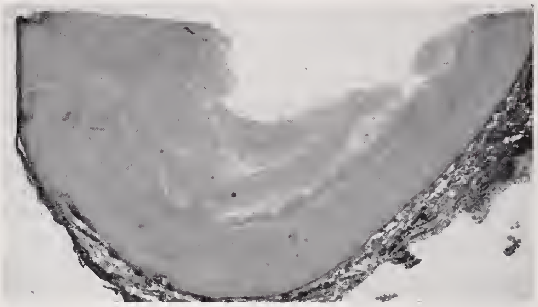

Fig. 4. Pulmonary granuloma due to Coccidioides involving the fissure between the upper and lower lobes of the left lung. Some of the soft necrotic material from the center of the lesion has fallen out, producing an apparent cavity. Hematoxylin and eosin. Reduced from a magnification of 7½ times. (AFIP Acc. 161851)

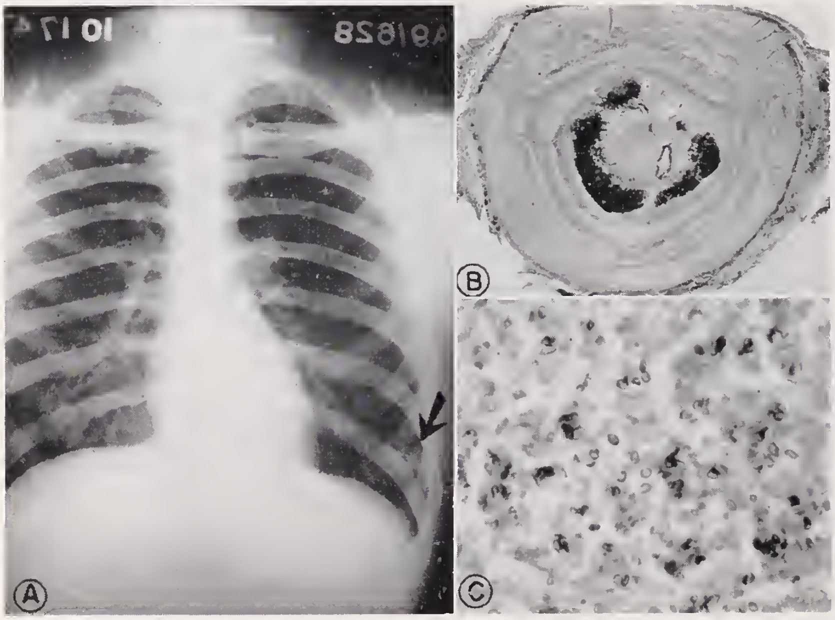

Fig. 5. Granuloma of left lower lobe due to Histoplasma.

A. A central focus of calcification is demonstrated in the roentgenogram of this smooth, discrete coin lesion (arrow).

B. Discrete subpleural lesion showing laminated pattern and focus of heavy calcification. Hematoxylin and eosin. Reduced from a magnification of 4 times.

C. The organisms are demonstrated clearly in the central necrotic area by the Gridley stain for fungi. Reduced from a magnification of 580 times (oil immersion). (AFIP Acc. 204744) have been labeled "mature" tuberculomas. Even in the latter there are small focal areas of softening, usually eccentrically located but toward the center of the granuloma. The semisolid contents of such foci may fall out on sectioning or may be scraped out by the bacteriologist. This explains the apparent cavity that is often seen when microscopic sections are examined (figure 4). Occasionally when communication with a bronchus is established, the caseous material may be discharged; air then enters and a true cavity is formed. Microscopic examination of the "tuberculoma" reveals the granuloma to be sharply outlined (figures 4, 5, 6, 7). There is an abrupt transition from normal lung parenchyma to granuloma. Only a very narrow zone of fibrosis and nonspecific chronic inflammatory reaction separates the necrotic central mass, which forms the bulk of the lesion, from the adjacent normal lung tissue. The necrosis is coagulative in type, the ghostly outlines of alveoli, bronchi, and blood vessels remaining discernible. Minute foci of degenerating leukocytes may be found where softening has occurred, but such changes are never conspicuous unless true cavitation has occurred.

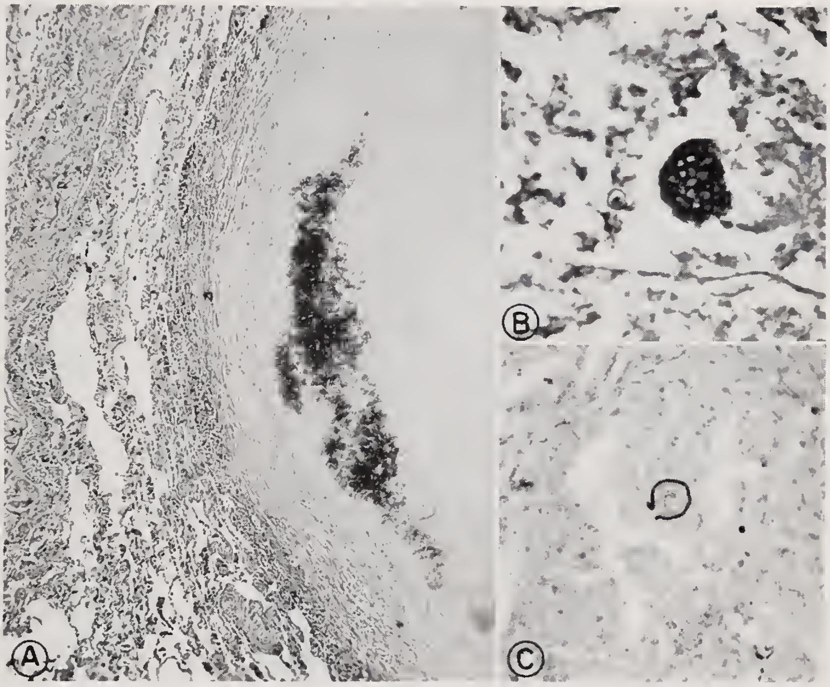

FIG. 6. Left lower lobe granuloma due to Coccidioides.

A. The lesion is sharply demarcated from the adjacent lung by a layer of dense connective tissue; focus of calcification. Hematoxylin and eosin. Reduced from a magnification of 48 times.

B. Mature sporangium filled with endospores. Periodic acid-Schiff reaction. Reduced from a magnification of 500 times.

C. Ruptured sporangium; endospores have been liberated. Gridley stain. Reduced from a magnification of 200 times. (AFIP Acc. 182987)

The tuberculoma, as its name implies, has been rather generally accepted as a lesion caused by the tubercle bacillus, even though proof of a tuberculous etiology usually is lacking. Mahon and Forsee,[3] for example, frankly state that smears and cultures of their mature tuberculomas were always negative for tubercle bacilli. In 3 of the 18 cases reported by Black and Ackerman[4] sputum studies revealed tubercle bacilli, but in only 1 case were the specific organisms identified within the lesion. Even skin sensitivity tests failed to corroborate the diagnosis of tuberculosis in many cases. Mahon and Forsee reported that only 70 per cent of their 48 patients had positive tuberculin tests, and many of these were positive only with second strength tuberculin. They stated, "Histoplasmin and coccidioidin tests may be equally positive. The coccidioidin skin test may be positive and the tuberculin negative, yet the lesion proves to be tuberculosis." Others have been more cautious in accepting tuberculosis as the only etiologic factor in these lesions. Although Storey and his associates[5] tabulated 70 per cent of their coin lesions under "tuber-

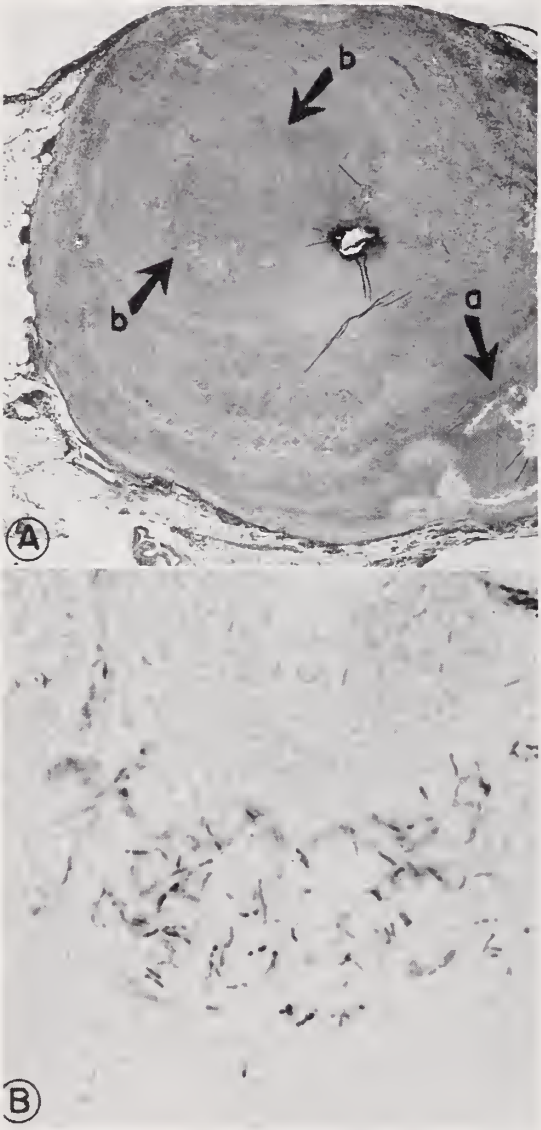

FIG. 7. Left upper lobe granuloma of tuberculous etiology.

A. Sharply circumscribed subpleural lesion with eccentric lamination. There is liquefaction necrosis at the periphery (arrow "a"). If such an area were to communicate with a bronchus, a cavity would develop. Arrows "b" indicate area in which acid-fast bacilli were found. Hematoxylin and eosin. Reduced from a magnification of 7 times.

B. Tubercle bacilli found in eccentric central focus of necrosis shown in 7-A. Acid-fast stain. Reduced from a magnification of 1,460 times (oil immersion). (AFIP Acc. 234977)

culoma," they carefully pointed out that the term was "applied only in a general rather than a specific sense, for only exceptionally was it possible to establish unequivocally the tuberculous nature of these nodules by the demonstration of tubercle bacilli by Ziehl-Neelsen stained smears. Even less often could tubercle bacilli be cultured from them." These workers suggested that some of their "tuberculomas" might actually have been produced by Histoplasma, Coccidioides, or other deep fungi. After a study of 65 pulmonary granulomas removed at the Mayo Clinic, Good, Clagett, and Weed[6] reported that 9 were tuberculous while 44 (68 per cent) were of undetermined etiology. Coccidioides was the etiologic organism in 4 cases, but none was found to be caused by Histoplasma.

It is well established that a granuloma indistinguishable on radiologic or morphologic grounds from tuberculoma may be the result of coccidioidal infection.[7] Only recently, however, was it shown that organisms identified morphologically as Histoplasma could be found in the so-called tuberculoma.[8] Supporting this direct observation were the results of intradermal tests. The histoplasmin skin test was negative in only 1 of 30 patients, while 9 reacted to neither first nor second strength tuberculin.[9] Puckett's histopathologic demonstration of Histoplasma was the result of a deliberate search in which the periodic acid-Schiff stain was employed.[10] The application of histochemical technics[10-13] to the demonstration of fungi in tissue sections has been a most important contribution to the recent advances in the field of medical mycology.[14]

The several stains for fungi have been used extensively at the Armed Forces Institute of Pathology in the study of a variety of inflammatory processes, including so-called tuberculomas. As a result, Puckett's observation of Histoplasma in the latter has been confirmed repeatedly. Many other granulomas of this type containing spherules or sporangia of Coccidioides have also been seen. On the other hand, Blastomyces, Cryptococcus, Candida, Aspergillus, and Mucor have not been found in the characteristic "tuberculomas," although our more frequent use of special fungus stains has demonstrated these fungi in other types of pulmonary infection.

In an effort to determine the relative frequency with which acid-fast bacilli, Histoplasma, Coccidioides, or other organisms might be found in so-called tuberculomas, a pilot study of 35 cases was undertaken.[15] The cases represented a consecutive series from the files of the A.F.I.P. coded "tuberculoma of lung." Selection of cases for inclusion in the study was based on (1) macroscopic and microscopic features characteristic of tuberculomas, as herein described, (2) adequate material for preparation of special stains for bacteria and fungi, and (3) lack of an etiologic diagnosis established by demonstration of specific organisms within the lesion.

In 8 of the 35 cases a specific etiologic agent was not demonstrated. Organisms acceptable as Histoplasma on morphologic grounds (figure 5) were found in the "tuberculoma" in 18 of the remaining 27 cases; Coccidioides in 3 (figure 6), and acid-fast bacilli in 6 (figure 7). This study, therefore, furnishes further evidence that the usual "tuberculoma of the lung" is more often a healed Histoplasma infection than a tuberculous lesion.

SUMMARY

There is now good reason to assume that many, perhaps most, discrete solitary granulomas in the lung periphery presenting characteristics of the typical "tuberculoma" as herein described are, in fact, not caused by the tubercle bacillus but rather by the endemic fungi, Histoplasma and Coccidioides. It behooves the pathologist to restrict his use of the term, tuberculoma, to the granuloma which, in addition to presenting characteristic macroscopic and microscopic features, can be demonstrated to have been caused by the tubercle bacillus.

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THERAPY OF ACUTE AND CHRONIC PANCREATITIS*

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Acute Pancreatitis

WHEN the diagnosis of acute hemorrhagic pancreatitis has been established, the course of therapy can reasonably follow a successfully conceived outline. However, when the diagnosis is doubtful and laparotomy is necessary to rule out abdominal catastrophic surgical conditions such as perforated peptic ulcer, intestinal obstruction, acute cholecystitis, etc., the management will depend upon the findings at the time of operation. It can be stated that operation should not be performed if the diagnosis is established. The Scandinavian surgeons in the early 1920's were among the first to report lowered mortality rates in the acute disease with conservative nonoperative therapy. American surgeons slowly accepted this concept, and since the introduction of this conservative method the mortality rate in the United States has been materially lowered. This is not the only reason for the lowered mortality rate, since other therapeutic measures have contributed successfully and will be briefly discussed. The mortality rate has dropped from a high average of around 60 per cent in the 1920's to the present level of 5 per cent or lower. This is a creditable achievement.

NONOPERATIVE THERAPY

Nonoperative management involves the following:

1. *Bed rest.*

2. *Intravenous therapy which includes intravenous glucose, blood, plasma and calcium.* Plasma, blood substitute or whole blood transfusions are employed in amounts comparable to the degree of shock. Many cases require none; the average case requires an occasional transfusion of blood, blood substitute or plasma; cases with extreme shock may require 4 to 10 transfusions over a period of several days. Calcium gluconate or lactate (10 c.c. of 10 per cent solution) is given once or twice daily in the more severe cases. Calcium is lost in the extravasated pancreatic fluid and in the process of saponification of the fat. Some reserve the administration of calcium when the blood calcium laboratory reading is lowered. Practicality, however, would suggest calcium administration in the average and severe cases, using the blood calcium determination for checking only. Valuable time may be lost if one awaits a laboratory report, and intravenous calcium in the amounts mentioned is not harmful, even if not always needed.

3. *Gastric drainage.* Continuous gastric decompression accomplishes the reduction of the amount of gastric juice in the duodenum and this reduces the amount of work required of the pancreas, resulting in the output of fewer pancreatic enzymes. Ostensibly then, gastric drainage puts the infected pancreas at rest as much as possible with nonoperative therapy and is a valuable procedure.

4. *Antibiotics.* It has been our custom to employ 2 antibiotics, penicillin and streptomycin. However, aureomycin, terramycin and erythromycin have been successfully used in combination with penicillin. Parenteral administration of the antibiotic is of course necessary during the period of gastric drainage. We can obtain good reports on almost any antibiotic for this condition. Change of antibiotic if

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clinical improvement is not prompt has been our rule, if there is any rule. Perhaps the prevention by antibiotics of bacterial invasion is the most important phase of the treatment.

5. *Drug therapy*. Banthine or atropine will also permit a slight reduction in pancreatic enzymes and can be regarded as resting the infected organ. Nitroglycerin may relax the sphincter of Oddi and has been regarded as successful by some.

Morphine and its derivatives must be avoided because they may produce spasm of the sphincter of Oddi and could thereby accelerate the infectious state. Demerol, phenobarbital or some other barbiturate, or codeine are preferable if pain is not controlled by the other agents.

6. *Sympathetic block*. Novocaine blocking of thoracic sympathetic chain T9 to T11 inclusive lessens the pain in the more severe, painful cases. We block the left side first. If pain remains severe, blocking of the right side may be done. Caution: Blocking of both sides may be dangerous in those patients demonstrating shock and should never be done if the patient is in severe shock. Experience in our clinic shows that sympathetic blockings are not often needed and may be abandoned.

We continue the bed rest, parenteral fluids, antishock therapy, gastric drainage, antibiotics, banthine or atropine, nitroglycerin, and calcium until improvement of the patient suggests relaxation of the efforts, usually from 2 days to 4 or 5 days. Gradual resumption of fluids by mouth and diet is practical. There is no real modification of the diet except that the step-up in amount and "heaviness" should be guided by the toleration of the patients. Some prefer a low fat diet for a period of weeks or months, but this has not been necessary in our experience. If the attack subsides satisfactorily, regular diet can ultimately be tolerated.

OPERATIVE THERAPY

If laparotomy is performed and acute hemorrhagic pancreatitis is found, "do very little if anything." An experienced operator will promptly recognize the condition. If gallstones are present, perform stone removal and cholecystotomy. If common duct stones are present, remove stones and drain the common bile duct as well as the gallbladder, if this can be done easily. If this requires considerable manipulation and time, remove gallstones and perform cholecystotomy. Allow the patient to recover from the acute attack and perform common duct surgery at a later and safer time. Decompression of the biliary tract is accomplished by these measures and will not permit the regurgitation of bile into the pancreatic duct under pressure.

If no biliary disease is found, the abdomen should be promptly closed without further ado, nonoperative régime immediately started, and the patient treated the same as if no operation had been performed. The abdominal contents must not be subjected to harsh, lengthy and unnecessary exploratory manipulation. Trauma in the presence of this severe infection may tilt the chances of recovery unfavorably. The lesion is an interesting one at laparotomy, but these inflamed organs should not be subjected to a promenade of curious hands.

Chronic Pancreatitis

The management of chronic pancreatitis can be practically considered in 3 phases of the problem. It is hoped that this arbitrary classification may lead to clarity. It must be recognized that some chronic cases may be subjected to consideration and operation in all 3 phases, reflecting as it does thereby treatment in echelons of maneuvering. All observers agree that medical therapy alone will accomplish very little in the control of this disease, and radiation therapy is not beneficial. Surgical therapy has successfully controlled the cases in the hands of surgeons who energetically pursue a proper operative course. Defeatism cannot be substantiated from the experiences of surgeons interested in the care of these patients. Unfortunately, many surgeons who have not and do not operate for chronic pancreatitis continue to register the results of the operative therapy as failures. Actually they are not qualified to comment. The plan of attack as outlined below is our present plan, and the results have been gratifying.

1. When gallstones, common duct stones, fibrosis and spasm of the sphincter of Oddi accompany pancreatitis:

Many authors on numerous occasions have commented upon the association of biliary tract disease and pancreatitis. Reports vary from 35 per cent to 67 per cent involvement of biliary tract disease in pancreatitis. Opie's impacted ampullary stone and the common channel situation support the contention that the two conditions are allied.[1] Every surgeon of experience has noticed induration in the head of the pancreas in cholelithiasis and choledocholithiasis, and has seen the patient suffer no pancreatic attacks after proper biliary surgery. No one knows how many cases are controlled by the biliary surgery alone, but there is no question that some, probably more than we think, are controlled by the biliary surgery.

If gallstones or common duct stones are present and chronic pancreatitis is known to be present, we perform cholecystectomy, remove common duct stones, and dilate the sphincter of Oddi. Cholangiograms are now performed more often at the operating table, and many surgeons rely upon these helpful studies to guide them. Mulholland and Doubilet[2] perform sphincterotomy for these cases and report good results. They were the first surgeons to suggest that a surgical procedure should be employed that would prevent regurgitation of bile into the pancreatic duct under pressure. Their original work deserves the greatest praise and has stimulated many others to employ procedures that create the same situation.

However, at Kennedy, we simply perform the biliary tract surgery, dilate the sphincter of Oddi, and place a T-tube in the common duct. Cholangiographic studies are made and the T-tube withdrawn about 3 months after the operation. This will permit recovery, if biliary tract surgery will control the pancreatitis.

2. The second group includes the treatment of patients with known recurring chronic pancreatitis whose biliary tracts have been successfully freed of pathology, or who have never demonstrated biliary tract disease and who are subjected to recurrent pancreatic attacks.

The operations which have been employed for this group are as follows:

a. Gastric resection
b. Sphincterotomy
c. Thoracic sympathectomy
d. Vagotomy
e. Choledocho-enterostomy
f. Partial or total pancreatectomy

Gastric resection, sympathectomy and vagotomy are employed on the conjecture that the amount of pancreatic enzymes will be reduced and thereby lessen the severity and frequency of attacks. Sympathectomy in some measure tends to control pain with varying degrees of success. Failure to control the disease sufficiently by these operations eradicates their use in our clinic. There remain two for consideration, sphincterotomy and choledocho-enterostomy. It must be emphasized that each of these procedures attempts to prevent regurgitation of bile into the pancreatic duct under pressure. The sphincter-cutting prevents it by eradication of sphincter spasm or fibrosis. The common channel situation requires some blocking of the distal duct (at the ampulla) for the introduction of the bile under pressure. But, sphincterotomy has not uniformly been successful in the prevention of recurrent attacks, although the benefit has been great in the hands of Mulholland, Doubilet and a few others. Also, morbidity and mortality may follow.

It occurred to us that if prevention of regurgitation of bile into the pancreatic duct under pressure is desirable, then total deviation of the bile away from the pancreatic duct should answer the problem. It is known that the Roux-Y principle will prevent attacks of cholangitis after choledochal-enteric anastomosis. Choledochojejunostomy en Roux-Y has been employed in 12 cases at Kennedy Hospital. The patients experience an occasional slight attack in the early postoperative period. After T-tube removal (3 months after operation) all patients have remained free of attacks regardless of the diet or heavy alcohol consumption. Some of the patients have been followed for 6 years. One stricture at the anastomosis was corrected by resection and re-anastomosis approximately 18 months after the original operation. It appears that control of these attacks is more satisfactory by this method than by sphincterotomy.

Objection has been made about the magnitude of the procedure and the possibilities of producing peptic ulcer by robbing the duodenum of the alkaline bile. Pancreatic juice is alkaline and remains undisturbed. No patient has developed ulcer so far. It is conceivable that a patient with the ulcer diathesis may well develop ulcer after choledochojejunostomy. One must make certain that the pancreatitis is not due to a penetrating duodenal ulcer. Two patients were explored with the choledochojejunostomy plan in mind, but at operation penetrating duodenal ulcers were noted and gastric resection was performed instead of the planned choledochojejunostomy. It would be courting disaster to utilize this procedure in an ulcer patient. Finally, if ulcer should develop in any case which could not be controlled medically, vagotomy and gastric resection should successfully handle the situation in most cases.

Most observers include the "burned out" pancreas in this group, because the pancreatic infection is then assuming its final state. These patients demonstrate steatorrhea and mild diabetes. Perhaps sphincterotomy would be the operation of choice in cases of the "burned out" pancreas. We have seen only 1 patient who was treated by sympathectomy (thoracic T9–T11). The pain has been lessened, but the patient continues with weight loss, steatorrhea and mild diabetes. He refuses sphincterotomy or choledochojejunostomy. A few surgeons have advocated partial pancreatectomy for the cure of recurring pancreatitis. Obviously, total pancreatectomy will cure the disease, but this operation carries a high mortality rate and leaves the patient a dangerous physiologic cripple. Partial pancreatic resection can conceivably control the disease, but it creates the same desirable shunting of the bile as obtained by choledochojejunostomy, and the control is the same as the shunting procedure, which is admittedly of less magnitude and much safer than pancreatico-duodenectomy. Resection of the tail alone, except for eradication of pseudocyst, cannot possibly control the disease.

I have performed partial pancreatectomy in 1 case. At operation the lesion in the pancreatic head suggested carcinoma, and although there was doubt in our minds at the table, the resection was performed. The lesion was benign. The patient has remained well. But I subjected a patient to an extensive procedure bearing a mortality rate of 19 per cent in our hands, instead of choledochojejunostomy, which in our hands has had no mortality in 12 cases. And what has been gained? The answer is simple—his pancreatitis has been controlled by the shunting of bile away from the pancreatic duct, which is much more safely accomplished by choledochojejunostomy.

3. The management of the third group is actually simpler than the first two. It contains the pseudocysts, which often develop as the disease progresses.

If the pseudocyst is located in the tail of the pancreas, excision is the method of choice and receives unanimous support by all workers on the subject. If it is located in the head or body, or if excision is not feasible in the tail, then either cystogastrostomy or cysto-enterostomy is performed. Cysto-enterostomy is preferably done with the Roux-Y procedure. Cystogastrostomy is a simple method which requires a small transverse incision in the anterior surface of the stomach and exposure of the posterior mucosa. At the point of attachment incision is made through the posterior mucosa into the cyst, its contents are aspirated, and the edges sutured with catgut. All patients have done well. Subsequent X-ray examinations have failed to reveal any abnormality. The fate of the cyst is not known, but it disappears as far as one can determine roentgenographically and clinically. It is necessary in a few of these cases to perform both operations, choledochojejunostomy to control the etiologic phase of the problem, and cystogastrostomy or enterostomy to control the cystic formation.

SUMMARY

1. It is apparent that the therapy in acute hemorrhagic pancreatitis as outlined is highly satisfactory. These efforts enjoy a lowering of mortality rates from a high of approximately 60 per cent to a respectable 5 per cent figure.

2. Chronic recurring pancreatitis can be controlled by proper surgical therapy. Accurate diagnosis is necessary, however, to accomplish these results.

3. Sphincterotomy and choledochojejunostomy appear to be the most reliable procedures.

4. A successful plan, employed at Kennedy Hospital in 12 cases, includes first an attack upon the biliary disease, if present. When biliary tract disease has been cleared, or no biliary tract disease is present, and recurring pancreatitis attacks occur, then choledochojejunostomy en Roux-Y has been extremely satisfactory in our hands.

5. The treatment of the "burned out" pancreas is not definitely decided at this time. Sympathectomy offers partial relief of pain without disease control. Sphincterotomy may be the procedure of choice in the "burned out" pancreas. It is believed that choledochojejunostomy is improper for the "burned out" case, since it may invoke serious reduction of duodenal alkali and contribute to ulcer formation.

6. Pseudocysts can be successfully treated by excision, if the cyst is located in the tail of the pancreas and removal is technically feasible. If not feasible, or if the cyst is located in the head or the body of the pancreas, cystogastrostomy or cysto-enterostomy have proved to be extremely satisfactory procedures.

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INFECTIOUS HEPATITIS: CLINICAL COURSE, DIAGNOSIS, AND TREATMENT*

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INFECTIOUS hepatitis is the most common inflammatory condition involving the liver. Its world-wide occurrence during World War II led to intensive study because of the military and economic factors which resulted in the loss of manpower. The causative factor is a virus which is a hardy one and may be present in human beings in a carrier state. Progress in study of the disease has been hampered by the fact that the virus transmits the disease only to human beings so that an experimental animal is not available. The medical profession owes much to the many conscientious objectors and prisoners in Federal prisons, since the human volunteers were largely derived from these two groups. Homologous serum hepatitis, the clinical course of which is indistinguishable after onset from the naturally occurring infectious hepatitis, is transmitted artificially by the parenteral injection of blood or blood products containing the virus. Table 1 lists the major features of the known characteristics of the viruses in these two forms of hepatitis.

TABLE 1

Comparison of Viruses of Infectious and Homologous Serum Hepatitis

	INFECTIOUS HEPATITIS (VIRUS A)	HOMOLOGOUS SERUM HEPATITIS (VIRUS B)
Incubation period (days)	15 to 35	50 to 140
Route of infection (experimental)	Parenteral or oral transmission	Parenteral inoculation only
Virus in stool	Acute phase ? Chronic and convalescent phase	Not shown
Virus in serum	Acute phase ? Chronic phase	Incubation period and acute phase Chronic phase
Virus in duodenal contents	Acute phase	Not present
Immunity		
a) Homologous	Present	Present (not absolute)
b) Heterologous	None apparent	None apparent
Prophylaxis with gamma globulin	Yes	No

The vast experience with the disease has elucidated some aspects of the process not clearly known prior to World War II. The liver biopsy technic has demonstrated the diffuse inflammatory process with degeneration and necrosis of individual cells in all parts of the liver lobules, producing a mottled appearance. Undoubtedly, the formerly diagnosed acute catarrhal jaundice was the same disease. A question of great import is the problem of residuals. It appears from recent studies of groups of patients who had their disease 2 years or more previously that more than 90 per cent of all patients recover completely. Only a small percentage develop chronic hepatitis or post-necrotic cirrhosis. Physicians can therefore be optimistic about the outlook in cases properly diagnosed and treated.

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* Presented, in part, at the Third Midwinter Seminar of The Medical Society of the District of Columbia, February 16, 1954.

CLINICAL COURSE

The clinical course in the average case of infectious hepatitis is demonstrated graphically in table 2. The main clinical difference between infectious and homologous serum hepatitis is in the type of onset in the latter, being insidious and the temperature rarely exceeding 38°C. (100.4°F.). There are exceptions to this, however. In the preicteric phase anorexia is almost constantly found, but here again one may encounter an occasional patient whose appetite has been maintained. In addition to the generalized malaise, ease of fatigability, chills and fever, and nausea with or without vomiting some patients have arthralgias and even more uncommonly skin rashes, such as urticaria. Curiously, a distaste for cigarettes is noted in many patients during the preicteric phase. This has also been reported in infectious mononucleosis, a disease which frequently involves the liver.

TABLE 2

Clinical Course of Average Case of Infectious Hepatitis

<table>
<tr><td>SIGNS</td><td>CHILLS
MALAISE</td><td>WEIGHT LOSS (Average 10 lbs.)
APPETITE RETURNS
← CLINICAL JAUNDICE →
(Average—20 to 30 days)</td></tr>
<tr><td>SYMPTOMS</td><td colspan="2">← EPIGASTRIC TENDERNESS →
(usually palpable liver)
← NAUSEA AND VOMITING →
← ANOREXIA →
← DISTASTE FOR CIGARETTES →</td></tr>
<tr><td>TEMP.</td><td>Up to 103°F.</td><td>← NORMAL →</td></tr>
<tr><td>W B C</td><td colspan="2">← LEUKOPENIA → ← NORMAL →</td></tr>
<tr><td>Phase
Days</td><td>PRE-ICTERIC
1, 2, 3, 4, 5</td><td>← ICTERIC →
6, 7, 8, 9, 10, 12, 14, 16, 18, 20, 25</td></tr>
</table>

It is to be kept in mind that the disease has great variance, ranging from extremely mild to the fortunately rare (less than 1 per cent in most epidemics) fulminating form that may have a fatal outcome in 7 to 60 days. The prodromal phase may be telescoped into a period of 12 to 24 hours, the patient not having much in the way of subjective symptoms. He notices, or is told by his family or friends, that his eyeballs and skin have become yellow. The severity of the prodromal phase cannot be correlated with the duration of the convalescent phase. Generally speaking, the more intense the jaundice the more severe is the hepatic involvement, although in some fulminatingly fatal cases jaundice is mild, if present at all.

Clinically, it is curious that in many cases when the jaundice appears the patient in a day or two begins to feel better. The anorexia, nausea, and malaise tend to improve, and fever, if present, usually disappears. In some cases, together with the dark brownish urine, light to clay-colored stools are noted. The jaundice and light stools, usually with hepatomegaly, indicate an intrahapetic obstructive phase, caused by the inflamed, swollen liver with compression of the biliary ducts. This is generally short-lived, a few days in most cases, but in some cases the obstructive phase may last for many days and raise the suspicion of extrahepatic obstruction. Pruritus occurs in 10 to 15 per cent of patients with hepatitis. In this phase, liver biopsy has been valuable in delineating the exact histologic process.

The outstanding physical finding is jaundice. The serum bilirubin may reach high levels, 15–30 mg. per cent in a few days, much more rapidly than these levels are reached in extrahepatic obstruction. At the other end of the spectrum are cases of hepatitis without any perceptible jaundice, the so-called anicteric hepatitis. This form is easier to diagnose in an epidemic of infectious hepatitis than it is to diagnose in sporadic cases which most civilian practitioners encounter.

Hepatomegaly of variable degree is usually present. The liver may be exquisitely tender, and this may lead to suspicion of the diagnosis in the preicteric phase. Occasionally pain in the right upper quadrant will be noted when running, or when riding on horseback or over a rough road in an auto, even before jaundice appears. In diagnosis the pain in infectious hepatitis may cause difficulty since it radiates to the back on the right side, or may become primarily epigastric or generalized over the abdomen. This may lead to hasty operation for gallstones or even exploratory laparotomy for an "acute abdomen." In this respect the generalization that jaundice is rarely an emergency (less than 1 to 2 per cent of jaundiced patients will require emergency surgery) gives added assurance to the physician that careful clinical and laboratory study of the course of the jaundiced patient for days, or even weeks, will be helpful rather than otherwise. This is extremely important, since patients with acute hepatitis do poorly with the added insult of anesthesia and surgery.

Splenomegaly has occurred in about 20 per cent of the cases in my experience. Cervical adenopathy, especially in the right cervical region, is not uncommon. In a small number of cases, probably less than 10 per cent, spider angiomata may be found. Generally speaking, these vascular spiders are found in the more severe cases. The weight loss due to the anorexia and nausea averages about 10 pounds. The average length of the disease is about 40 to 50 days, but here again the spectrum is broad, jaundice remaining in some cases for several months.

LABORATORY TESTS

The ordinarily available liver function tests that are helpful are listed in table 3 with their normal values. A very valuable piece of information early in the disease is the white blood cell count. Leukocytosis practically rules out infectious hepatitis, or if hepatitis is present indicates a complication or a superimposed infection. The white blood cell count is normal or low, with a fairly frequent increase in the mononuclear and lymphocytic cells. Occasionally, the white blood smear simulates that found in infectious mononucleosis, but the heterophile antigen reaction is negative in infectious hepatitis.

TABLE 3

Liver Function Tests Used

PROCEDURE	NORMAL VALUES
Bromsulfalein	0–5%
Prothrombin	50–100%
Serum bilirubin	Indirect—0.2 mg. % Total—1.0 mg. %
Cephalin cholesterol flocculation	0–2+ (48 hours)
Thymol turbidity	0–4 Maclaglan units
Cholesterol	150–250 mg. %
Cholesterol esters	50–65% of total
Alkaline phosphatase (serum)	1–4 Bodansky units/100 c.c.
Albumin	4.5–5.5 Gm. %
Globulin	1.5–3.0 Gm. %

In the preicteric phase, testing for bilirubin in the urine with a commercially available tablet (Ictotest) may be helpful, since there is a bilirubinuria, even prior to the appearance of jaundice. The bromsulfalein dye excretion test and the flocculation tests are also usually abnormal in the preicteric phase. When jaundice appears, the cephalin cholesterol flocculation test of our honored guest moderator, Dr. Franklin M. Hanger, is positive in 85 to 90 per cent of the cases, a very good batting average. The tests indicating alterations in gamma globulin, the thymol turbidity and zinc sulfate turbidity tests, are also helpful. Fractionation of the cholesterol esters, while not used routinely in our clinic, may be of some value, since the ester fraction is generally diminished. The serum bilirubin should be followed serially, since it gives us a clue to the rapidity of the healing process in the liver. It is always a good idea to determine the prothrombin content, since this is markedly diminished in severe cases and will be a guide to vitamin K therapy.

Although the mechanism of the elevation of serum alkaline phosphatase in liver disease is not clear, we find this to be a valuable test. The elevations in hepatitis are usually modest, in the 8 to 15 Bodansky unit range. However, it may rise to higher levels, overlapping with levels usually considered indicative of extrahepatic obstruction. It should be also remembered that marked elevations may occur in primary or secondary cancer of the liver, usually, but not invariably, with jaundice.

Serial urine urobilinogen determinations are readily performed and are valuable in following the course of the disease. The levels (normal is 0.3 to 1.5 Ehrlich units in a 2-hour specimen of urine) are increased in the preicteric phase. With jaundice, the urine urobilinogen may become normal or markedly diminished. Daily determinations are important in ascertaining the presence of the intrahepatic obstructive phase and to determine the duration of that phase. During most of the icteric phase of the disease the values are normal but again become increased in the convalescent phase.

A question that frequently arises in the convalescent phase of hepatitis concerns what laboratory tests to use in determining when a patient can resume full activity. When the patient feels well, has his normal appetite, and his jaundice has clinically receded, we begin to allow moderate ambulation. We use a serum bilirubin of less than 2.0 mg per cent and the bromsulfalein dye retention of less than 8 per cent to denote resumption of normal activity. Even when these criteria are attained, there may be some residual hepatomegaly or liver tenderness and the flocculation tests may be abnormal, but we feel that activity at this stage, with these criteria, will not interfere with complete recovery.

Diagnosis

An illustration of some of the problems in diagnosis of infectious hepatitis can be gleaned from a review of a case which was seen in consultation after surgery.

ILLUSTRATIVE CASE

A 49-year-old white man was well until 2 days prior to admission, when ease of fatigability, slight fever, and malaise were noted. One day prior to admission fever and headache developed. The temperature was 104.8°F., and he was given penicillin. Chills and perspiration were also present. On the day of admission the temperature was 100–102°F., and he noted dark urine, cigarettes tasting poorly, nausea, and anorexia for 3 days. There did not appear to be any jaundice when he was examined on the first day of hospitalization, and the liver was not felt. On the third day after entry scleral icterus was noted. The jaundice deepened in the hospital, and the temperature fell. By the seventh day the jaundice was deeper. Laboratory tests were as follows: hematocrit 50 vol. per cent; hemoglobin 15 Gm.; white blood cell count 3,850, 3,900, 9,300, per cu. mm.; icterus index 50 to 100; urine urobilinogen 0.06, 2.4, 12.96 Ehrlich units; alkaline phosphatase 21.0 Bodansky units; thymol turbidity 9.8 Maclaglan units; serum bilirubin 0.74/1.15 5.1/7, 8.6/13.2, 11.2/14.5, 6.15/12.8 (1 minute direct/total) mg. per cent; prothrombin content 100 per cent.

The patient had his operation on the eighth day, and no stones or common duct lesions were found. A node in the region of the common bile duct was found, removed, and a liver biopsy made. Cholecystectomy was done. The liver biopsy showed acute viral hepatitis.

It is noted that there was a fairly typical preicteric phase with fever, chills, malaise and anorexia. The white blood cell counts were low, and when jaundice appeared the temperature became normal. The urine urobilinogen was first very low but then became markedly elevated. The level of 12.96 Ehrlich units should have indicated to the clinicians the absence of obstruction of the extrahepatic biliary tree. The jaundice deepened rapidly from a serum bilirubin level of 1.15 to 14.5 mg. per cent in several days. This is also more typical of infectious hepatitis than of extrahepatic obstruction, in which the rise is more gradual over a longer period of time. Despite these data and an elevated thymol turbidity test, the presence of an alkaline phosphatase of 21.0 Bodansky units influenced the attending physician and surgeon to operate on the assumption that the case represented extrahepatic obstruction. This case emphasizes what was pointed out earlier with reference to levels of serum alkaline phosphatase in hepatitis overlapping with levels usually associated with extrahepatic obstruction. It is also interesting to note that the last serum bilirubin determination prior to surgery was less than the previous determination, indicating another reason to have delayed surgery. Fortunately, in this case, the patient recovered from his hepatitis without incident after surgery.

TREATMENT

Treatment is quite simple and consists of bed rest and a nutritious diet. In the first few days in the average case there may be nausea and vomiting, preventing oral intake of food. Intravenous dextrose in water, up to 2,000 c.c., daily should be used in such cases. However, in most cases the diet can be taken after several days. If it is deemed necessary, intravenous dextrose may be used to supplement an inadequate intake. In the severe cases intravenous therapy may be required for longer periods of time.

Complete bed rest is advised and will be accomplished when the patient feels poorly, as he does early in the disease. However, it is remarkable how well some deeply jaundiced patients feel after a short time and how difficult it is to attain the ideal of complete bed rest. We have to compromise with the ideal, and we can see no harm in allowing bathroom privileges when the patient feels up to it. The physiologic basis for bed rest is sound: the blood flow to the liver is decreased when the patient is in the erect position or when he exerts himself. There have been reports of series of cases of hepatitis treated with a regimen of "ad lib bed rest," allowing the patient to determine the amount of bed rest. There is little question that some of our patients do this in practice, but empirically it is our belief that too early and too strenuous activity will lead to more of the relapsing, recurrent variety of infectious hepatitis that one occasionally encounters. It is our opinion that adequate bed rest during the active phase of the disease, the criteria of which have been previously cited, reduces the eventual relapses, residuals, and disability from an attack of infectious hepatitis.

There has been a good deal written and said about the type of diet that is best in hepatitis. In my opinion, a common-sense, nutritious diet that agrees with the patient and is one that he will eat should be allowed. There is no scientific evidence that a low-fat or fat-free diet shortens the course of the disease or reduces relapses or residuals. Eliminating some fats in the form of butter, cream, cheese, and ice cream may make the diet so unpalatable that an anorexic patient eats less than he would if the diet were palatable. Probably we should aim at a goal of 3,000 calories. The question of high protein content being beneficial is also not clarified. It appears that 100 to 150 grams of protein are at no disadvantage when compared with diets containing greater amounts of protein. Forcing protein to higher levels has been done in a series of large numbers of patients with infectious hepatitis in an overseas area in the armed forces. There have been no clear-cut advantages in cases receiving 4,000 calories and

190 grams of protein, and, indeed, there was pointed out by the observers some potential disadvantages. Eating a nutritious "ad lib diet" appears to me to be as good a goal as any to obtain in treating this disease, with the evidence gathered on this aspect to date.

What about the use of antibiotics in the usual case of hepatitis? There is no evidence to support their usefulness, and, indeed, in a few instances some of these substances may have an injurious effect. However, aureomycin has been used in hepatic failure, but the results appear better in chronic liver disease than in severe infectious hepatitis. There is no rationale, despite some advertisements, for the use of methionine and choline which are lipotropic factors and increase the fat turnover in the liver. On histologic examination of biopsy specimens in infectious hepatitis, the absence of fat is quite noteworthy. Vitamin B_{12} has been advocated to improve the appetite in hepatitis, but this effect is difficult to evaluate since the appetite soon returns in most patients. The prothrombin content determination guides one as to the use of moderate dosage of vitamin K or K_1, since there is no need to use it if the prothrombin content is normal.

In a careful investigation, with the use of serial biopsies, an Army group found that cortisone and ACTH tend to shorten the duration of the jaundice phase of infectious hepatitis. However, the results in the average case were not sufficiently better than cases treated without these steroid substances. No one advocates their use in the average case. In the severe case of hepatitis or the fulminating variety there have been reports indicating possible dramatic results from ACTH or cortisone. I believe that in such cases there is probably no harm in its use if the patient is followed closely, especially for fluid retention which, usually present in hepatitis, may be markedly accentuated by ACTH or cortisone. In my limited experience I have not been impressed by the results, but fortunately most physicians see very few of these severely ill patients. The following case report outlines a severe case of infectious hepatitis and failure of ACTH to alter a fatal issue.

ILLUSTRATIVE CASE

A 9-year-old white boy became jaundiced several days before admission to the hospital. Jaundice and hepatomegaly were found on admission. Laboratory data were consistent with hepatocellular damage. Three weeks after admission he was discharged for Christmas with a serum bilirubin of 20 mg. per cent. He reentered 8 days later because of nausea, vomiting, deep jaundice, and moderate ascites, and the serum bilirubin was 40 mg. per cent. ACTH HP gel, 30 units b.i.d., was administered on the thirty-fourth day of the disease. Rounding of the face and acne of the forehead were noted 4 days later. Over a period of a week the serum bilirubin rose to 62 mg. per cent and ascites increased. ACTH dosage was reduced. Neurologic findings, disorientation, and finally coma supervened, with death 47 days after the onset of the disease, and 13 days after the start of ACTH therapy. At postmortem the liver weighed 960 grams and revealed severe acute hepatitis.

In this case the patient was allowed too much activity at a time when his serum bilirubin was markedly elevated. Certainly, as complete bed rest as is possible should have been continued in this youngster, despite the fact that he was not feeling too bad. On reëntrance to the hospital his serum bilirubin was 40 mg. per cent, and at this time adequate ACTH dosage was started. This was the thirty-fourth day of the disease, and one can only speculate that starting it earlier might have made a difference in the outcome. He survived for nearly 2 weeks, but it was apparent that ACTH had not affected the course in this unusually severe case of hepatitis.

The author will be glad to furnish references on any of the aspects of infectious hepatitis covered in this paper.

FEAR AND PHOBIAS[*]

Part II

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FAVORABLE psychologic soil must exist for a phobia to develop. From our study of the phobic type of defense thus far, it must be apparent that the capacity for the formation of a phobia must antedate later symptom formation. In other words, a characterologic predisposition must exist for the adoption and use of this type of attempted defense against anxiety.

This points up not only the individual specificity of the type of emotional defense adopted, but also the relative susceptibility of different people to emotional stress. For example, a large number of people could theoretically be exposed to stressful situations of similar degree and likely only a very occasional one might develop a phobia. Some of the others might develop other types of emotional reactions in various degrees or combinations. Many would show little or no apparent effects. Thus the development of neurotic emotional defense is marked by great specificity and by a high degree of individuality (table 2).

It should be noted that the complexity of phobias varies greatly. Fenichel[24] observed that "In certain cases there is not much displacement; anxiety is simply felt in situations where an uninhibited person would experience either

TABLE 2

Some Mechanisms and Terms Employed in the Study of Phobias

A. Mechanisms, all of which operate outside of and beyond conscious awareness:

1. Displacement—The automatic transfer of fear and threat from its original hidden and internal source to another one which is external and apparently completely unrelated to the person concerned.
2. Extension—The progression of a phobia to include related objects and areas.
3. Externalization—The emotion of an internal conflict is outwardly directed. In a phobia the affect of the unbearable idea is directed externally and attached to an apparently previously neutral object or area.
4. Generalization—The extension of the original phobia, more generally to include many related areas or things.
5. Idealization—The concentration upon and exaggeration of the liked attributes of an individual so that everything about the "idealized" person comes to be seen in a fine light. Negative aspects may be unseen or forgotten.
6. Projection—The assignment of one's own ideas, motives and feelings to another. Sometimes used to indicate the outwardly directed affect from internal conflicts (more properly referred to as "externalized"). The attributes which he has assigned beyond conceived awareness are to him real and he reacts accordingly.
7. Reaction formation—The development of outward attributes and attitudes opposite to internal concealed wishes and drives.
8. Replacement—of the actual internal object by a substitute external one.
9. Repression—The involuntary and automatic relegation of unbearable ideas and impulses from conscious awareness into the unconscious.
10. Substitution—of the phobic object for the hidden unacceptable original object.
11. Symbolism—The external object representation for hidden internal objects and meanings.

B. Terms:

1. Ambivalence—Mixed feelings. Usually the simultaneous presence of opposite emotional feelings, e.g., love and hate.
2. Anxiety—The apprehensive tension or uneasiness

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This is Part II of the ninth article in a series by Dr. Laughlin covering the psychoneuroses. The final article of the series, "Neuroses Following Trauma," will appear in the September and October issues.

"Fear and Phobias" will be a chapter in a forthcoming psychiatric text by Dr. Laughlin, entitled "The Neuroses," which will be published early in 1955 by W. B. Saunders Co., Philadelphia, Pa.

TABLE 2—*Continued*

arising from: (1) hidden emotional conflicts, (2) by empathic and intuitive communication, (3) as a consequence to aggressive or helpless feelings, (4) in response to a threat, etc. In anxiety the source of danger is not clear.

3. Anxiety-hysteria—Freud's term for the phobic reactions.
4. Association—A relationship between ideas by contiguity, continuity, or by similarities. An associative thought is the normal, unimpeded progression of ideas from the preëxisting one.
5. Cathexis—The attachment of emotional feeling and significance to an object or idea. By cathexis the new idea, object or situation becomes invested with increased psychologic significance.
6. Dependency needs—Vital infantile needs for mothering, love, affection, food, and warmth. Can become more inclusive, often symbolically so in later years.
7. Emotional amalgam—In phobias, the joining of the free or poorly attached anxiety (often at the time of the critical attack) through displacement to the new and unconsciously selected external phobic object.
8. Fear—An uncomfortable state of apprehension or uneasiness; "the emotional response to recognized external danger."[1] Lay usage often makes no distiction from anxiety.
9. Phobia—(Gr., *phobos*—flight; panic, fear such as causes flight) A phobia is an obsessive, unrealistic fear which is inappropriate and unreasoning; "a morbid fear, out of proportion to the apparent stimlus" which is attached to a specific external object or situation. Displacement has been effected out of conscious awareness from the actual but hidden and internal object.
10. Phobic avoidance—The modern "magical" adaptation of the "flight" from the primitive "fight or fight" response to danger. The avoidance of the external phobic object.
11. Phobic endogain—The basic primary gain in denying, concealing or controlling anxiety, which is sought through the operation of the various mental mechanisms involved in the development of the phobia, operating outside of conscious awareness.
12. Phobic object—The objectively neutral external object which is threatening and feared in a phobia.

sexual excitement or rage." Perhaps one might add feelings of closeness, warmth, or tenderness. Fenichel continues shortly, "for such cases . . . what a person fears he unconsciously wishes for." (See also case 4.)

In other and still simple phobias, the feared situation does not represent a feared temptation; rather it is the (accompanying) threat that causes the temptation to be feared. The individuality of phobias has been referred to. The selection of a phobic object offers almost unlimited variety, from the specific phobia of knives or cats to the phobia of "a part of the universe" as in agoraphobia (Deutsch[25]) or the earlier cited phobia of travel (case 8). As pointed out earlier by Laughlin and Ruffin,[26] "At times one may make a guess at the psychologic significance of a particular phobia in a particular individual. While this sort of intellectual exercise may occasionally be accurate, the only real proof is to be found in a therapeutic working out of the meaning with the patient."

The phobias are related to hysteria. Up to a point the emotional reaction is similar.[5] It seems to me also that there is a similarity between the near-magic of the conversion of anxiety into a bodily form of expression in hysteria and the likewise near-magic of its displacement to a symbolic external object in the phobias. Similarly with each, it is sometimes possible by suggestion or hypnosis[8] to remove the symptom.* Compare also the massive dissociation of the conversion hysteria with the great emotional splitting away by displacement in the phobia.

Freud early suggested and himself used the name "Anxiety-Hysteria" for the phobias. This term is occasionally seen in the current literature but has not gained wide acceptance in psychiatry generally. This name is appropriate dynamically. From the psychopathologic relationship of conversion hysteria and anxiety hysteria, displacement of anxiety is the prominent feature in both. In the former it takes place in to the body in the form of disabilities and physical ailments† and in the latter it is displaced on to outside objects or situations.

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* This is a dangerous procedure and should be interdicted in therapy or for experimentation. The sudden removal of a defensively vital hysterical or phobic symptom by hypnosis or suggestion opens the likelihood for a more dangerous sequela.[8] Schmideberg[27] related a story told by Jones in which the rapid cure of a case of agoraphobia by Freud was followed in a few days by signs of acute schizophrenia. Freud was reported to have suggested under hypnosis the return of the phobia.

† Dr. William C. Menninger properly points out that the

The rapid dissolution of a specific phobia occasionally takes place dramatically through recall (de-repression) of the "forgotten" original traumatic situation. This took place in Bagby's case[11] of the phobia of running water upon sudden recall at the age of 20 of the much earlier traumatic situation at the time of onset (age 7). In the following case a well established phobia of coughing disappeared in similar sudden fashion following the second interview.

Case 9. *A phobia of coughing.* The 26-year-old husband of a patient came to discuss ways in which he might better support his wife's therapeutic efforts. During our discussion, which was on a very friendly basis, he mentioned a disturbing phobia about coughing. He became very anxious whenever someone coughed, or if he did so himself. A coughing spell literally filled him with panic. He could not recall the original time of onset and, although I indicated interest in any further possible details, I did not press him for information.

I managed to see him at his request for a second hour several days later. He had in the meantime set an approximate date of onset and had had a few thoughts of interest about the phobia, for example, a "loose" or fluidy cough was much more frightening, etc. As he began telling me these additional thoughts, suddenly in dramatic fashion and with great emotion he recalled the initiating situation in vivid detail. At age 9 he, with his family, was in a serious auto accident although he was personally unhurt. An uncle was critically injured and while awaiting medical help was carried into the nearest farmhouse where he lived an hour or so with the boy in attendance. The uncle's chest was crushed and he struggled constantly and in labored fashion to breathe. There were repeated attacks of coughing as he gradually lost the fight to keep his respiratory system open and free of the steady hemorrhage.

With this recall of the initiating traumatic situation and accompanying abreaction of emotions, the phobia vanished and, although I have not seen the patient since, the phobia itself has remained cured. Obviously we can't know what the dynamics were here since further therapeutic investigation was not possible. I am sure, however, that many readers will have some shrewd guesses.

This case may help call attention also to the earlier observation, that regardless of the kind of traumatic situation, it serves as the precipitating event in psychologic soil already well prepared. Thus resolution of the phobia itself is a limited therapeutic goal. Ideally speaking, deeper characterologic study is needed. This might be compared to a similar view with hysterical symptom removal. The fortuitous misadventures in early life which often are uncovered where the phobia had a sudden onset are convenient pegs upon which to hang the existing but latent capacity for phobic development. These include also such emotionally traumatic and frightening events as tornadoes, near-drownings, mishaps with animals, thunderstorms and lightning, death and physical or sexual assaults. In this context, with recovery to conscious awareness of the traumatic initiating event, the phobia per se may be cured. This does not mean that the underlying conflicts are necessarily resolved, however, nor is the capacity for future phobic flight necessarily changed. From this context, however, one can also perhaps take a more tolerant view toward public health people doing education in cancer, in so far as possible unwitting responsibility for an increased incidence of cancer phobia is concerned. If this peg were not available, susceptible people might well find another. One could look at the undue fearful responses to polio in a somewhat similar light and still not discount the fact that it is possible to frighten people with sufficient provocation. Francis Bacon wrote, "Men fear death as children fear to go in the dark; and as that natural fear in children is increased with tales, so is the other" (Maxims of the Law: Of Death).

Phobias are also closely related to the Obsessive-Compulsive Reactions.[28] Following Janet's inclusion of phobias in his category of "psychasthenia," the three mostly remained grouped together until 1952.[2, 3] Phobic reactions are frequently seen in patients with obsessional neuroses. This may be illustrated in the following

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somatization or psychosomatic reactions "are just as much conversion reactions as is a paralysis." (Personal communication, May 25, 1954.)

clinical example of a less well marked fear reaction which is phobic in character.

Case 10. *A phobia of people* (*anthropophobia*). A 37-year-old psychologist was in intensive treatment for handicapping and limiting character defenses of an obsessive nature. Among his emotional problems was a fear of people. This fear often interfered with his going to theaters or restaurants, which he could only manage at the cost of considerable uneasiness. We gradually worked this out to be largely a projection and displacement of his own hostility and intolerance. The injury and hate he expected from others was a projected expression of his own resentment. The combination of deep roots for his own feelings and the generalization to people as the phobic object makes the latter both symbolic and circumstantial.

The fears gradually subsided as we learned more of their mechanisms. We began their understanding through some experiences he was able to report from playing golf. He began to notice how angry he was toward fellow club members for their misuse of equipment, their failure to replace divots, and their manner of dress and behavior. He deplored their "poor tastes," "boorish manners and loud talk." This very critical attitude paralleled his own terrible level of self-criticism coming from a judgmental, overdeveloped conscience.

There was a relationship here also to competitiveness. This had roots extending into sibling rivalry and the oedipal situation. Still farther back there was antecedent dissatisfaction with the sought after object of dependency. There was a failure of gratification. My patient said in effect, "If Mother really cared enough she would treat me better." Here it is the same thing all over again with the men at the club. As he said in effect, "If they respected me enough they would behave better out of consideration for me. With them I had projected my own resentment and hostility at their failure to do so and now it seems to me that they are threatening me in turn and are therefore to be feared, dreaded, and avoided." The maternal conflict is antecedent and is in accord with the Theory of Antecedent Conflicts (see later).

For other dynamic formulations which may be applicable here the reader is referred to the Obsessive Personality and the Obsessive-Compulsive Neuroses.

In passing it may be of interest to note that Freud was himself phobic. We have earlier noted the fainting attack in Munich when the affect of the disagreeable experiences was displaced to their locale. As Reik[16] recounted a later confidence given to him by Freud some years after this incident as cited, Freud in hesitating to cross a street said, "You see there is a survival of my old agoraphobia which troubled me much in younger years." The presence of this emotional difficulty could enter into the explanation of many things, e.g., Freud's considerable interest in phobias, his early (circa 1894) pessimism about their therapeutic resolution,* and his later carefully detailed case histories of phobias.[15, 18] His inability to more completely clear away his own agoraphobia is consistent with his relative paucity of definitive dynamic contribution in this particular type of phobic defense. It has remained for the contributions of Helene Deutsch,[25] W. Schmideberg,[27] A. Katan-Angel,[30] Fenichel,[31] and others to help us better understand the dynamics involved in agoraphobia.

In our current understanding of dynamics many psychiatrists would agree that the emotional roots of agoraphobia extend not only into the Oedipus complex and its vicissitudes but also through and beyond, into the still more deeply buried earlier area of oral dependency and its conflicts. This has been formulated earlier. According to this point of view, antecedent oral conflicts underlie the later conflicts and vicissitudes of the oedipal situation. This is in accord with my own Theory of Antecedent Conflicts, according to which every difficult emotional situation theoretically has roots in a primordial antecedent. It is possible to speculate that Freud himself believed his primary problem to be in his relationship with his father. On a deeper, less clearly recognized level it more likely extended further back to antecedent problems in his relationship with his mother. Freud's resulting concentration upon and possible overemphasis on the basic importance of the Oedipus complex has had profound influence on the development of the dynamic understanding of human emotions and behavior.

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* E.g., ". . . in the phobias of the anxiety-neurosis (1) this affect is always the same, always that of anxiety; (2) it does not originate in a repressed idea, proves not reducible further by psychological analysis, and is also not amenable to psychotherapy."[29]

One of my reviewers has directed my attention to some accessory data. Jones[17] in his excellent book reported Freud's phobia of traveling on a train. This phobia, which appears to have lasted from 1887 to 1899 (age 31 to 43 years), was carried back by Jones' comments (likely Freud's own analysis) to indicate roots into the early level of oral conflict. It appears that Freud incorrectly recalled the date of the occasion of an early traumatic train trip in which undoubtedly part of the foundation for the later phobia was likely laid. This resulted in its being placed timewise more within the oedipal period. Apparently Freud, although certainly aware of oral conflicts on the one hand, at the same time assigned the predominant role in human psychology to the important unconscious sequelae of the Oedipus conflict. Jones on an adjoining page cites Freud's discovery of the universality of the latter as his greatest contribution. Were certain implications missed of an important underlying and antecedent oral area? The implication is that knowledge was present of oral conflicts. Was the significance of these as important antecedents underlying the later oedipal conflicts overlooked at this time? Was the relative importance of the former overshadowed by Freud's emphasis upon the latter?

As the reader has by this time doubtless realized, any systematic classification of the phobias is rather difficult. The phobic defense is highly individual. Phobic objects are legion and mechanisms in the same phobia can show wide variation. From this standpoint the phobias might be regarded as a whole series of related illnesses rather than a single disease entity. Naming of many individual phobias has been done on an empiric, descriptive basis. Many of the names thus applied seem more confusing than helpful. We shall accordingly use only a few of those which are most widely accepted and used. I shall tabulate these names and simply list other more common phobias according to their object (table 3). It is obviously impossible

TABLE 3

The More Common Phobias

A. By their technical names with their derivation indicated:

1. Acrophobia—A morbid fear of height (Gr., *Acra*—heights or summits; acro is singular)
2. Agoraphobia—Open spaces (Gr., *Agora*—market place; the place of assembly)
3. Ailourophobia—Cats (Gr., *Ailouros*—cat)
4. Anthropophobia—People (Gr., *Anthropos*—man, genetically)
5. Aquaphobia—Water (Lat., *Aqua*—water)
6. Asterophobia—Lightning (Gr., *Asterope*—lightning)
7. Ceraunophobia—Thunder (Gr., *Ceraunos*—thunderbolt)
8. Claustrophobia—Closed spaces (Lat., *Claustrum*—bar, bolt or lock; by metonymy means a barrier or bounds)
9. Cynophobia—Dogs (Gr., *Cynas*—dog)
10. Equinophobia—Horses (Lat., *Equinis*—horse)
11. Herpetophobia—Lizards or reptiles (Gr., *Herpetos*—a creeping or crawling thing)
12. Mysophobia—Dirt, germs, contamination (Gr., *Mysos*—uncleanliness of body or mind; abomination or defilement)
13. Numerophobia—A number or numbers (Lat., *Numero*—number)
14. Ophidiophobia—Snakes (Gr., *Ophis*—snake or serpent)
15. Nyctophobia—Darkness or night (Gr., *Nyx*—night; Lat., *Nox*)
16. Pyrophobia—Fire (Gr., *Pyr*—fire)
17. Self-confining phobia—Phobically imposed area or spatial restrictions
18. Zoöphobia—Animals (Gr., *Zoos*—animal)

B. On a descriptive, empiric basis according to the phobic object:

1. Airplanes
2. Aloneness
3. Anger
4. Animals
5. Arguments
6. Atomic explosions
7. Birds
8. Blood
9. Boats
10. Cancer
11. Cats
12. Childbirth
13. Closed spaces
14. Confinement
15. Crowds
16. Dark
17. Death
18. Dirt
19. Disease
20. Doctors
21. Dogs
22. Fights
23. Fire
24. Flowers
25. Genitals
26. Germs
27. Heights
28. Horses
29. Hospitals
30. Illness
31. Insanity
32. Insects
33. Knives
34. Lightning
35. Lizards
36. Medicine
37. Men
38. Mice
39. Night
40. Occupations
41. Old Age
42. Open spaces
43. People
44. Poison
45. Poliomyelitis
46. Rats
47. Rodents
48. Senility
49. Sex
50. Sharp objects
51. Snakes
52. Solitude
53. Spiders
54. Strangers
55. Syphilis
56. Thunderstorms
57. Travel
58. Venereal disease
59. Vermin
60. War
61. Water
62. Women

to discuss each phobia and its dynamics in any detail in a presentation of this sort. I have tried to select certain fairly representative and interesting cases for clinical illustration, making no attempt to cover the field. Actually clinical and theoretical research in the phobias has been limited. Further study and research offers a challenging area for the interested student.

Psychiatrists are aware of cultural influence upon the incidence of types and variations in emotional illness. These influences tend to bring about what might be called a vogue in symptoms. This cultural vogue is apparently slowly changing with perhaps some clear enough difference in "styles" of emotional illness for detection each interval of several decades. I do not refer here to short-range effects of "contagion" via suggestibility which occasionally have been seen.* The influence of a cultural vogue is perhaps best illustrated in conversion hysteria,[8, 32] in the phobias, and in paranoid delusions. In the former we have seen a gradual but substantial decrease in the incidence of gross conversion reactions since World War I.

With the phobias the changes have been in the changing "popularity" of certain phobic objects. Around the sixteenth century, demons, sorcery, witchcraft and Satan were in vogue. Around the 1920's syphilophobia was relatively common, whereas almost without exception the only instances I have seen in recent years have been associated with incipient or active schizophrenia. Currently, cancer phobia, fear of airplanes, fear of poliomyelitis, and, to a lesser extent, atomic phobias have increased in frequency. The "popularity" of certain phobic objects, e.g., water, height, closed spaces, open spaces, insanity, dirt and certain animals, appear to remain rather stable. Similar changes are seen with paranoid patients, who are more concerned currently with TV and Communists, these having superseded wireless, radio, dictaphones, and Nazis.

I have earlier mentioned the hyperacute ability of the phobic patient to "find" his phobic object and offered one dynamic formulation in attempted explanation. On occasion the ability of the phobic patient to make these frequent unwelcome contacts seems uncanny. As deCervantes pointed out in "Don Quixote" (Ch. 6:131), "Fear is sharpsighted and can see things under ground and much more in the skies." Thus we must really often doubt that such frequent contacts are solely the result of chance or accident but are unconsciously determined despite the patient's best conscious efforts to the contrary. This seeming capacity of the phobic patient supports an hypothesis which I have offered about the "selectivity of attention."[33, 34] According to the Attention Hypothesis, "our attention is selectively directed towards those qualities in others over which we have concern or conflict in ourselves."

Thus, we are selectively attracted to those people whose characterologic make-up most fits our own inner needs, healthy or neurotic. Our attention is selectively directed in automatic and semi-automatic fashion to a much greater extent than we are consciously aware. Similarly, and more discernibly, the photographer thinks in terms of subjects, setting and background; the stamp collector can spot an interesting postage stamp from a distance; the sports car enthusiast likewise with sports cars, and many teen-age boys with make and model details of cars. The psychiatrist may have an affinity for words beginning with "psych" which are seen by him to stand out from a printed page. As Rangell[9] stated, "When one chooses an object for a phobia, he in a sense becomes married to the object. In order to avoid it, his eyes seek it out. He finds it in obscure places, he sees it with his peripheral vision."

What is the reverse of a phobia? What is its opposite? It is interesting that no consideration has been given previously to this side of the coin.

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* E.g., "epidemics" of headache, G-I upsets, or backache, etc. have been seen at times in a fairly large proportion of the soldiers in a given barracks. These instances are more apt to be seen during basic training, boot camp, or while awaiting overseas duty.

We might offer the thought that the reverse of the neurotically feared and threatening symbolic or adventitiously selected object is the neurotically loved and protected one. This represents ultimately the symbolic achievement of the neurotically sought after object of dependency. Certain primitive charms, talismans and gods might be the forbears of such magically protective objects. Certain modern rituals, ceremonies, collections and love objects are present-day examples. In neither instance, however, is attention directed as to the more troublesome phobic situation.

As a corollary to our attention hypothesis, things that trouble us or cause painful feelings are more a matter for concern than things which do not. Hence the phobic object, with its neurotically attached affect of threat and fear, troubles and concerns us; the neurotic love object with its pathogenic love and protection is a comfort and a pleasure and is much less apt to be a matter of concern. It is, therefore, not surprising that little consideration has been given to this "other side of the phobic coin." Neurotic feelings of being loved and protected much less obviously cause pain or trouble.

In concluding these clinical observations, I would like to observe that there is considerable basis to support a phobic character type similar to those I have outlined for the Hysterical, Depressive and Obsessive Personalities. However, the concept of the phobic personality is not yet worked out well enough in my mind to attempt any clear delineation at this time.

Treatment

As has been my custom in considering the various neuroses thus far, this section will be limited to a few remarks with some application to the treatment of emotional disorders generally, together with several specific points in the therapy of phobias.

The therapist soon learns to recognize the extreme tenacity with which people cling to old and established patterns of behavior and response. This is not only because of the attraction of the familiar and oft-used pathway, but also illustrative of the vital defensive purpose. To the objective, interested observer the net self-destruction and defeat may be clearly apparent. They may be partially apparent on an intellectual level to the person concerned. Efforts to point this out to him often meet with indifferent success. In any event, however, such established patterns are never easily surrendered. The concept of the defensively intended "gains" of emotional illness is vital and useful, although the so-called "gain" itself is parodoxically a net loss. An understanding of the unconscious origin and defensive intent of emotional symptoms is vital to the development of the necessary resources to attempt to effect their resolution.

Psychotherapy is a terribly complex business. Only too few people have the requisite personality, interest, patience, skill and training to undertake it with reasonable chances of success. Unfortunately, however, the wide field of emotional problems invites attempts at intervention by well-meaning but untrained people in a way not seen in any other field of medical practice. Not infrequently these people regard themselves as possessing an undeserved degree of skill and competence in a way that would simply never occur to people concerning a field, for example, like surgery. Yet the fine judgment, reasoning ability, and the combination of art and science requisite to sound psychotherapy are at the very least as complex as that required for the most delicate and complex surgical procedure. Family, friends, work associates, ministers or physicians who sincerely wish to assist the person with emotional problems would not even remotely give a second thought to tackling any kind of surgical procedure. Yet they may with the greatest impunity and blindness often assume competence to offer specific direction and advice in all kinds of tenuously balanced and potentially explosive emotional situations. This is less true in the well marked severe and distinct psychiatric entities. It is almost unusual not to see some evidence of this sort of thing in the milder neuroses and character defenses, areas in which the competent psychotherapist can often render his most effective service.

Such unskilled interference blocks therapy, often at a critical time when every genuinely constructive force had best be mustered in support of the patient's perhaps only too slight interest in constructive self-study with expert assistance. Advice leading to the trying of alternatives, or delay, to see if time, or this, or that or the other will help solve matters is a vote in favor of the illness, not one in favor of its solution and defeat. A sometimes even more destructive result can be the prevention of even subsequent steps toward seeking definitive help at some later date. An unsuccessful or painful experience or the increase of prejudices and personal resistance as the consequence of any ill-advised therapeutic attempt can add immeasurably to the problems which many patients have to solve to even begin treatment, in some instances contributing to it becoming forever impossible. These implications to ill-advised amateur intervention are indeed tragic.

With many cases the completion of definitive treatment even in the hands of the most competent psychotherapist who is eminently suited to the particular patient, and when the patient himself is highly coöperative can take years of hard work. This is a reflection of the difficulty and complexity of the work.

The specific well-established phobic defense is a major therapeutic challenge. It is proportionately more difficult when (1) the phobia is the major emotional problem with little initial evidence of concurrent difficulties, (2) the more effectively it operates to control anxiety, and (3) when it is well established and severe. In direct ratio to the degree of these are often (1) the relative difficulty in interesting the patient in treatment, and (2) the tougher and more drawn-out the therapeutic problem involved. The reverse also roughly applies.

Mild phobia reactions are quite common as demonstrated in many cases seen in psychotherapy or psychoanalysis for different reasons initially. Many of these are no more difficult to handle and resolve than are other psychologic defenses.

Regardless of the level of symptoms, the goals of treatment are approximately similar in all types of emotional illness.* Stated simply, they include:

1. Improved external environmental adjustments, including the ability to initiate and maintain constructive relationships with people.
2. Improved internal adjustment (conflict recognition, resolution, and a better level of personal integration).
3. The surrender of socially destructive and personally inimical patterns of behavior.
4. Improved function, increased effectiveness and increased ability to satisfy realistically adjusted needs and goals.
5. Self-acceptance with increased genuine self-respect, a closer approximation of the self-picture with that held by others, and the ability to recognize and to accept the pressure of inner drives and wishes.
6. A higher level of emotional maturity with all its implications as to constructive and satisfying individual and social adjustment.

The psychoanalyst seeks understanding and emotional maturity. He is constantly interested in clarifying data and in probing into hidden meanings. In his armamentarium while in the pursuit of clarification, one of his most important words is "Why." Another is "How." With many types of emotional illness, the study and interpretation of dreams is an important adjunct to treatment. This is also true in the therapy of fears and phobias. Lewin, who early contributed to our understanding of claustrophobia[35] (see also Schmideberg[22]) more recently wrote on "Phobic Symptoms and Dream Interpretation."[36] The following case illustrates how a dream helped in the partial understanding of a fear of women of sufficient strength, persistence and interference with adjustment to probably earn the designation of a phobia.

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* Not only are therapeutic efforts similar in all types of emotional illness, but the dynamics of symptom formation likewise have much in common. Thus, in response to anxiety, repression of various intolerable impulses and ideas takes place. These repressed impulses cause the symptoms.

As a colleague points out, "It seems to me that as stated in 'Emotional Maturity' probably all neurotic symptoms contain expressions of the fight-flight reaction; in other words, they are partly expressions of regressive impulses, a form of psychological flight as well as defense and also partly expressions of and defense against hostile impulses."—Leon J. Saul, M.D. (Personal communication, June 9, 1954.)

Case 11. *A fear of women.* A 33-year-old housewife in treatment suffered from a handicapping fear of women. This fear was poorly understood until an early dream fortunately provided some useful leads. The dream was reported as follows:

"I was at the club. There were many members (women) there. I was unafraid and at ease. I thought to myself, 'I really belong here. This is my element.' There was a strange realization that I wasn't afraid. I wasn't on the alert or defensive. I wasn't feeling threatened. I was happy and could be there without fear."

The dream was interesting because of its terrific contrast with her usual reactions to women. It occurred to her that she was actually more comfortable at the club, one which largely included women considerably older than herself. We learned there was a correlation of her degree of fear with the age of the woman concerned. In the dream every one of the women was definitely older. Gradually we worked out that the older ones did not pose the danger to my patient that the younger ones did. Her fears were much stronger in regard to younger women.

The danger was in competition, a danger which she believed she could not face since it must inevitably end in defeat for her. In early years the original instruments of what she had experienced to be certain defeat for her in competition had been 2 younger sisters who, she felt, had enjoyed preferential parental acceptance and favor. Her reactions to older women more closely followed the pattern of her early relationship to her grandmother and an aunt. As she said many months later, "I felt I ought to have a place in my family. I couldn't with my parents. I had a place with grandmother and my aunt. This was the only place I could get."

This is different from younger women, who became for her her own projected competitive self. They were indeed threatening, since she "regarded" her own inner hidden competitiveness to be murderous in level. This made it threatening and greatly feared. It became repressed as a control measure and at the same time was disguised through projection. Again I would carry back the internal hostile aggressive rage, now subjectively experienced as threatening, in its disguised projected form, to its original primordial origin. This would ultimately be the long and deeply buried infantile rage toward the dependent object, mother. It was repressed as unbearable. These infantile feelings not only threaten the dependent object, but their control and concealment fit in also with the implied promised return for good behavior, i.e., "then I will be fed, and cared for and loved."

If the phobic patient could talk "from his unconscious," he might say in effect, "I want something and I'm going to be punished for it. My phobia is a line of defense, frightening me away from something I want, but for which I must deny my wish, the securing of which would be symbolically disastrous. My phobia indicates that I (the ego) feel I am in a precarious state of equilibrium between my unbearable hostile impulses toward my needed object and my simultaneous hidden dependent needs upon it." There are other implications here for which there is insufficient space. Suffice it to say that this bit of insight aided substantially in the understanding of her phobia and led into some interesting and therapeutically useful ramifications of her emotional life.

The indirect approach to solving a phobia is often more fruitful than any direct questioning, urging or active probing. It is always useful to attempt sooner or later to trace a specific phobia to its day of onset, but this is better accomplished in the absence of direct pressure. Indeed, the indirect approach holds considerable validity in psychotherapy generally. Marshall Erwin Rommel[37] interestingly described his advocacy of the indirect approach in military tactics in North Africa in World War II, where the flank assault and circle around consumed more time and covered more distance, but for effectiveness was usually beyond comparison with the direct frontal assault. In psychotherapy rather similarly the longer approach can often prove to reach the desired goals much more rapidly.

The recall of the traumatic precipitating situation (when present) and its clarification can result in dissolution of the phobia per se.[12] (See case 9.) Ideally therapy does not end here, as it should similarly not end when the gross hysterical symptom is vanquished. Treatment should continue in order to secure constructive realignment of the phobically predisposed character structure.

Many other factors of interest concerning phobias can be noted. Miller[38] reported the cure of a combat-precipitated phobia in a pilot under brief psychotherapy. Deutsch[25] gave an excellent description of a phobia of hens which is classical and can help with the understanding of therapy. She also discussed several cases of agoraphobia and their analysis. Lawrance[39] reported a severe case of mysophobia in a 42-year-old woman with agitation and depression which was recalcitrant to therapy. Feldman[40] in discussing the "Fear of Mice" points out in case illustrations how the origin, specificity, and content of this fear vary widely. Ferenczi,[41] following one route of the phobic object as symbolically representing the protection against and the rejection of that which is unconsciously wished for, interpreted "the fear of being buried alive as the transformation into dread of the wish" (an internal one and which, since unbearable, must be denied, disowned and protected against) "to return to the womb."

In closing I would like to emphasize an important point in the relation of surgery and psychiatry. By now I would think it very clear that surgical procedures are always to be considered with special judiciousness in emotional illness. This is most particularly true in cases of depression and hypochrondriasis. Ordinarily these conditions constitute absolute contraindications to elective surgical procedures. Surgery should only be undertaken under the clearest emergency and only then following careful consideration. Perhaps one will wonder at my mentioning this here. However, let me ask this question: How many exploratory laparotomies are required to cure a cancer phobia? An infinite number will not suffice. The true phobia stems from deeply hidden psychologic needs. It is not rational and will not respond to reason or logic or to the sometimes anticipated reassurance of negative organic findings. At times in this regard the phobia can approach the delusion in character, although the phobic patient is ordinarily distinguished in his ability to recognize the inappropriateness of his reaction.

Phobic patients can sometimes exert certain indirect but compelling pressures, hence the caution to the surgeon. Surgery in which reassurance to the patient with a phobia is any part of the rationale is absolutely contraindicated.

One might also ask similarly, "How many examinations will cure a real phobia of poliomyelitis?" Here again such a goal is impossible. The physician can at least spare himself frustration if he is aware of this. Finally, it is only fair to ask, "How many psychiatric hours are required to cure a phobic patient?" The answer: One must anticipate that many, many hours will be required with no guarantee as to result. Here at least, however, one has a good chance with the coöperative patient who is willing to work together with the psychiatrist in a mutually collaborative endeavor. It may be a strenuous job, taking hundreds of therapeutic hours over some years, but the end-results can be well worth the investment of time, effort and money.

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President's Page

THE COMMUNITY AND THE DOCTOR

Although the organization year is less than two months old, it has already become evident to me that we physicians must become more community-minded. Somehow we must meet the needs and demands of the people of the District of Columbia.

Health problems in this community are diverse and complex. Here are a few matters which should receive our earnest consideration:

Effective regulations governing sanitation
Adequate facilities for the care of the chronically ill
A more comprehensive lay health-education program
Improvements in the care of the mentally ill
Renewed attack upon the venereal disease problem
Further efforts to solve medical care problems, many of an economic nature.

These and many other matters will challenge committees of our Society in the next year. I have no misgivings about the chairmen of the committees. I know many of them personally, and I am confident that they will fulfill their obligations to the community and the Society. I am sure, too, they will find among members of their committees men who are equally conscientious.

If ever there was a time when there was a need for community-minded doctors, it is now.

Preston A. McLendon

Editorials

WHAT PHYSICIANS OWE MEDICAL SERVICE

Blue Shield is medicine's best answer to the charge of sterility in health protection. It is a positive calculation with definitive action. Under its shield physicians are witnesses for the effectiveness of our self-determining way of life.

In guiding it to full fruition each physician has a continuing obligation to his own Blue Shield Plan for prepaid coverage of specified physician services. This obligation is not only for value already received through its stabilizing influence in avoiding radical or even revolutionary solutions to the modern problem of health protection. It is more especially a need to protect a large investment in a mechanism which has become a part of our daily life.

The fulfillment of this duty is dependent first of all upon a knowledge of the details of function of the plan—an expanding service to more than 425,000 citizens of the community by more than 1,600 physicians. This requires regular attention to the sources of information developed for this purpose.

Letters to Participating and Coöperating Physicians list and explain specific items of immediate concern. Such letters are associated with the *Bulletin*, which contains more background information and is worthy of careful perusal. The annual meeting of Participating Physicians with all related matters for discussion and action is an important source of information which has been generally neglected. While the Trustees can take pride in this as an indication of trust in their functioning, they view it with alarm as evidence of the continued existence of the Achilles heel of democracy—lack of the interest to remain well-informed.

The national advertising program which is now being conducted by Blue Cross and Blue Shield in *Life*, *Look*, and the *Saturday Evening Post* should be noted by all physicians. However, it is even more important that they follow closely the frequent displays of Medical Service and Group Hospitalization in the Washington newspapers. This program is expected to make it generally known that Group Hospitalization is Blue Cross and that Medical Service is Blue Shield and what these groups are doing and can do locally and nationally.

Perhaps the most important item in the program of Medical Service to inform the physician will be the new Handbook now being prepared, to contain in looseleaf form a working summary of all the facts needed to work with the Plan.

The knowledge gained from these sources can easily be the basis for more intelligent decisions by the profession in this field of health protection than we have ever known.

Knowledge alone, however, is not enough. Actions must still have moral guidance. While all the evidence indicates honest and moral behavior by the vast majority of physicians, our batting average is not so good in the matter of policing the few who fall short. Perhaps the very generosity and consideration which mark our treatment of our patients, as well as the knowledge that medicine is not an exact science, tends to temper our judgments. Also it is almost universally true that individuals are less scrupulous in their relation to institutions than to other individuals.

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia

A full knowledge of all the facts will lead to the considered judgment that each physician should know the Plan to be a coöperative effort which he should consider as he would a fellow physician in his dealings with it and which he therefore would protect from the rare exploitation by another physician or hospital. This proper attitude of protection by its physicians may well be the basis of survival by Blue Shield as the bulwark of private practice.

Hand in hand with moral support of the Plan must go a concerted effort to maintain medical standards. This requires a careful balance of the supervised teaching with private patients which is rapidly becoming a necessity in most voluntary hospitals. It requires active support by the entire profession of the separation between Blue Cross coverage of hospital service and Blue Shield coverage of Physician Service. It means also that the AMA definition of Pathology, Radiology, Anesthesiology and Physiatry as the practice of medicine must be effectively implemented. Especially in this area where Medical Service deals with hospitals directly only when collection rights have been assigned by a physician, it is essential that the physicians guard this relation. This cannot be overemphasized.

Medical Service has no right to interfere in the practice of medicine except to urge always that its patients receive the best care. The detailed manner in which this standard is maintained must remain in the hands of the profession. Steps must be taken, however, to show each physician that he has a personal stake in this problem.

Another point at which physician relations are crucial to the future of Blue Shield is in the preservation of the "service benefit" by which "under income" subscribers are covered in full for the specified service. This is the one point of outstanding difference between these physician plans and all others. Fee schedules may be modified and coverage areas extended but the service benefit must be maintained.

All the foregoing is an outline of the physicians' obligations to Blue Shield. The obligations of Blue Shield to the physician and its contributions to his interest are the chief concern of the Board of Trustees, and their periodic reports have all dealt with this aspect of joint duty.

When all physicians have the detailed knowledge, the informed degree of guiding morality, the active interest in maintaining medical standards separated from hospital service, and the protective instinct aimed at the support of Medical Service, we will be well on the way to eliminating its deficiencies and setting it properly as the outstanding instrument in this community for health protection. Then our dedicated actions will speak anew for a truth expressed by John Donne 150 years before our Declaration of Independence: "No man is an Iland, intire of it selfe; every man is a peece of the continent, a part of the maine; any mans death diminishes me because I am involved in mankinde; And therefore never send to know for whom the bell tolls; It tolls for thee."

Donald Stubbs, M.D.
President, Medical Service
of the District of Columbia

WORLD CONGRESS OF CARDIOLOGY

If it weren't for the worldwide confusion that would result, the time for celebration of the New Year ought to be changed in the North Temperate Zone. January first is a silly time to have the year begin. It comes right in the middle of things—not at the beginning.

When dog days are ended, and people have had their Labor Day last fling, and the nights have turned cool—that's when a new round of activities has its start. That's the beginning of a year. At least it is for physicians.

In Washington this September, physicians will start their new year with extraordinary vigor. The occasion is the Second World Congress of Cardiology, September 12 to 17. About 3,000 physicians will assemble from all parts of the world for the largest and perhaps the most important meeting ever held in the field of heart and vascular diseases. The Congress will be held in conjunction with the annual scientific session of the American Heart Association.

The list of participants in the program for this meeting reads like a "Who's Who" of cardiovascular experts. The scientific papers will be given simultaneously in English, French, and Spanish; summaries will be published in the program in five languages. There will be more than 50 scientific exhibits and 70 or more selected industrial exhibits.

All meetings except the first will be held at the Armory. The Congress will open on Sunday morning, September 12, at Constitution Hall. That evening there will be a reception at the Pan American Union. The National Gallery will be open Monday night especially for the congressionalists. Tuesday night there will be a banquet; Thursday night, a concert by the National Symphony Orchestra.

Attendance at the Congress is open to any who are interested. Fees for registration range from $5.00 (residents, interns, medical students, nurses—for scientific sessions) to $25.00 (members—for all social and scientific events).

On the afternoon of September 15, the medical schools and hospitals of the city will present scientific programs of their own for members of the Congress. These meetings will be held in the respective hospitals. Arrangements for this and for the hundreds of other details that had to be worked out locally have been the responsibility of the Washington Committee of the Congress (Drs. Bernard J. Walsh, *Chairman*, Clayton B. Ethridge, W. Montague Cobb, William R. Haas, Henry Cooper, Thomas W. Mattingly, and Charles R. Mueller).

H. H. H.

MEDICAL METHODS IN POLICE WORK—A QUESTION OF ETHICS

With increasing emphasis, various scientific methods are being employed in the detection and conviction of crime; some of these methods are those devised for the use of physicians. They are mostly of a laboratory nature (alcohol content of the urine or breath; identification of stains as blood, etc.) and therefore the physician enters the scene merely to corroborate other facts developed by the police. Occasionally, however, the medical man may be asked by the investigating authorities to go somewhat beyond his traditional role and become an active *particeps investigationis*. This request may, among other things, raise a point of medical ethics, a question which of course is, in the vast majority of cases, answered properly by the physician.

A recent case in which a physician assumed the role of an investigator has just been decided by the United States Supreme Court (Leyra v. Denno, 347 U. S. 556, June 1, 1954). A man in police custody in New York City, suspected of killing his parents, after five days of intensive police interrogation, complained of a painful sinusitis and asked the police for medical assistance, whereupon a physician employed by the state (actually a psychiatrist experienced in hypnosis) was brought in. There followed an interview of over an hour (the transaction being recorded on tape) of hypnotic suggestion, urgings, promises of leniency and threats. Finally the prisoner succumbed to the procedure and confessed the murder. As the Court phrased it: "An already physically and emotionally exhausted suspect's ability to resist interrogation was broken to almost trance-like submission by use of the arts of a highly skilled psychiatrist." The Court found that "the use of confessions extracted in such a manner from a lone defendant unprotected by counsel is not consistent with due process of law," and reversed the conviction.

The use of medical skills to coerce a defendant into a confession, as the Court found happened in this case, is beyond the accepted function of the physician and happily is extremely rare. The duty of the medical man is primarily to treat the ill; his knowledge may also be useful in the process of administering the law, but only within the limitations imposed by the principles of fair play, which after all is what is meant basically by "due process of law."

W. O.

DELEGATES' REPORT ON AMA MEETING IN SAN FRANCISCO, JUNE 21–25, 1954

In spite of the threat to their security that came with an early proclamation that cigarette-smoking shortens life expectancy, and in spite of the shock to their dignity that came when some hotel reservations did not materialize, the members of the House of Delegates of the American Medical Association worked through an enormous number of resolutions and other items of business in the four days of their meeting. In addition, Dr. Elmer Hess of Erie, Pennsylvania, practicing urologist and long-time member of the House of Delegates, was named President-elect for next year. Dr. Walter B. Martin, Norfolk internist, took office as President. Dr. William Wayne Babcock, Philadelphia surgeon, was voted the 1954 Distinguished Service Award. Places for future annual meetings were lined up for five years ahead: Atlantic City, 1955; Chicago, 1956; New York, 1957; San Francisco, 1958; Atlantic City, 1959.

Items of Local Interest

Chief in this category were the activities of the Conference of Presidents and Other State Medical Officers—an annual prelude to the opening session of the House of Delegates. This year Mr. Theodore Wiprud served as Secretary of the Conference—assisted in the preparation of a program that rooted a large physician-audience to their seats during a sunny San Francisco Sunday afternoon. A highlight of the program was a panel on physicians and the press.

Dr. Herbert P. Ramsey discussed the physician's point of view. His remarks were enthusiastically received. Others on the panel with Dr. Ramsey were Mr. Steven M. Spencer, Associate Editor, *Saturday Evening Post*, and Mr. Alton L. Blakeslee of the Associated Press.

Mr. Wiprud was elected a member of the Executive Committee of the Conference. Later in the week, he was appointed to the AMA's Public Relations Advisory Committee for a three-year term.

Acting for the Medical Society of the District of Columbia, Dr. Raymond T. Holden introduced a resolution to the House of Delegates on the subject of the Armed Forces Medical Library. This resolution called attention to the importance of the Library to Medicine and to the Nation, mentioned the inadequacy of the present Library quarters, reiterated the belief that a new building deserves immediate priority, and called for active AMA support toward the erection of the new building on the site already designated by the Secretary of Defense (National Naval Medical Center). Dr. Holden supported the resolution in hearings of the Reference Committee on Legislation and Public Relations. That committee recommended adoption of the resolution, and this was done.

The Council on Medical Service presented a supplementary report outlining the difficulties encountered in conducting the Seal of Acceptance program, and recommending discontinuance of the Seal of Acceptance for voluntary health insurance plans. The report said that the standards and principles of the program will be maintained as guides and recommendations for all groups operating or establishing plans. The House, on recommendation of the Reference Committee on Insurance and Medical Service, adopted the Council report, thus terminating the Seal of Acceptance program for voluntary health insurance plans. This action eases an important local problem in connection with Group Health Association, Inc. That association had been approved by the Medical Society of the District of Columbia some time ago, but the Seal of Acceptance had never been granted by the AMA.

THE NATIONAL BLOOD FOUNDATION

A highly significant action of the House of Delegates was the adoption of a report of a negotiating team representing the American Medical Association, the American National Red Cross, the American Hospital Association, the American Association of Blood Banks, and the American Society of Clinical Pathologists.

The report authorized setting up a "National Blood Foundation," jointly participated in and supported by these five organizations to coördinate and standardize blood banking throughout the United States and possessions. The adoption of the report was made contingent upon an appraisal of the legal and financial implications of the new Foundation.

Dr. Ramsey is Co-chairman of the AMA's Committee on Blood.

MEDICAL ECONOMICS

Fee Splitting. The House adopted a supplementary report of the Reference Committee on Miscellaneous Business which recommended acceptance of a Judicial Council report on the subject of billing and made the additional recommendation "that the House of Delegates resolve that it firmly opposes fee splitting, rebating or payment of commissions in any guise whatsoever, and that it further opposes any mechanism that encourages this practice."

The Judicial Council report included the following statements:

> "The Judicial Council is of the opinion that the only new facet concerning this subject that has come up recently is the case of joint billing to some of the nonprofit insurance companies. In many cases these insurance companies insist on a joint or combined bill, but the bill is being paid in most instances by two checks. This is not considered unethical and all insurance plans which do not pay the individual physician in this manner should be urged to do so.
>
> "The Judicial Council is still of the opinion that when two or more physicians actually and in person render service to one patient they should render separate bills.
>
> "There are cases, however, where the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur it is considered to be ethical if the physician from whom the bill is requested renders an itemized bill setting forth the services rendered by each physician and the fees charged. The amount of the fee charged should be paid directly to the individual physicians who rendered the services in question.
>
> "Under no circumstances shall it be considered ethical for the physician to submit joint bills unless the patient specifically requests it and unless the services were actually rendered by the physicians as set out in the bill."

President McCormick's Remarks. In his address at the opening session of the House of Delegates, Dr. Edward J. McCormick, then president of the AMA, urged that physicians adopt and publicize average fee schedules on an area or regional basis. He named three advantages for such schedules: First, they would serve as a basis for discussion of fees between patient and physician. Second, they would provide insurance companies with information that would be valuable in preparation of lists of benefits from health insurance policies. Third, physicians would be further discouraged from making exorbitant charges. The House of Delegates later approved a suggestion that the Board of Trustees make a study of programs of average fee schedules where they are already in use.

MEDICAL PRACTICE

Osteopathy. Four resolutions dealing with the osteopathic problem were considered. The House of Delegates accepted a recommendation by the Reference Committee on Medical Education and Hospitals and adopted a Supplementary Report of the Board of Trustees on a Report of the Committee for the Study of Relations between Osteopathy and Medicine:

> "The justification or lack of justification of the 'cultist' appellation of modern osteopathic education could be settled with finality and to the satisfaction of most fair-minded individuals by direct on-campus observation and study of osteopathic schools. The Committee, therefore, proposed to the Conference Committee of the American Osteopathic Association that it obtain permission for the Committee for the Study of Relations between Osteopathy and Medicine to visit schools of osteopathy for this purpose.
>
> "The Conference Committee favorably recommended this proposal to the board of trustees of the American Osteopathic Association which considered it at a special meeting on February 6–7, 1954. It has referred the question to its house of delegates which will act upon the proposal in July, 1954. If the action of the house of delegates of the American Osteopathic Association be favorable, the on-campus observations can be carried out in the fall of this year.
>
> "The Committee therefore recommends:
>
> "1. That no action be taken on the report at this time and that final action be deferred until December, 1954.
>
> "2. That the Committee be continued until December, 1954, in order to be available to evaluate education in schools of osteopathy should the house of delegates of the American Osteopathic Association act favorably upon the recommendation of its Conference Committee."

Closed Panel Plans. The much-publicized New York resolution, calling for several changes in the Principles of Medical Ethics relative to participation in closed panel medical care plans, was considered by the Reference Committee on Miscellaneous Business. That committee made the following recommendation, which was adopted by the House:

"In the discussion before your reference committee on this resolution, it became apparent to the committee that clarification and interpretation of the Principles of Medical Ethics in relation to prepaid medical care plans are desirable. As set forth in the by-laws, the Judicial Council has jurisdiction on all questions of medical ethics.

"Therefore, your reference committee recommends that the House of Delegates request the Judicial Council to . . . investigate the relations of physicians to prepaid medical care plans and render such interpretations of the Principles of Medical Ethics as the Council deems necessary, and report to the House of Delegates not later than the next annual meeting of the Association.

"The committee further recommends that the New York resolution be referred to the Judicial Council for consideration in connection with this investigation."

The New York resolution, among other suggested changes, would add the following new paragraph to Chapter 1, Sec. 4, "Advertising," of the Principles of Medical Ethics:

"It should be understood that any medical care plan, company, or organization which advertises for subscribers and directs such subscribers to a restricted panel of physicians for medical care is advertising for the benefit of the physicians involved."

FEDERAL MEDICAL SERVICES

Veterans' Medical Care. Accepting a report by the Reference Committee on Legislation and Public Relations, the House adopted two strong resolutions condemning the present practice of establishing service-connection for veterans' disabilities by legislative fiat. In recommending passage of both resolutions, the committee said:

"The study of the chronological expansion by law and regulation, together with evidence presented of pending legislation now before a Congressional Committee, emphasize all too clearly the imperative need of decisive action on the part of the American Medical Association.

"It is the opinion of the Committee that the time is at hand when the American Medical Association and its component societies should go all out in preventing this unscientific method of determination of service-connected disabilities, and that we respectfully request that copies of these resolutions be transmitted to the Congress of the United States and other appropriate Federal agencies."

In connection with veterans' medical care, the House also adopted recommendations by the Reference Committee on Insurance and Medical Service which reaffirmed the policy on nonservice-connected disabilities, established at the 1953 annual meeting, and which commended the informational program carried out since then by the Committee on Federal Medical Services of the Council on Medical Service.

Medical Military Scholarships. On this topic, the following report of the Board of Trustees was adopted.

"In December, 1953, a resolution requesting that the House of Delegates endorse the principle of federally subsidized scholarships for prospective military personnel was referred to the Board of Trustees for prompt and careful study and action. The resolution was considered by the Council on Medical Education and Hospitals, the Council on National Emergency Medical Service, and the Committee on Legislation, and as a result of these deliberations the following statement was submitted and has been adopted by the Board:

"The proposal in question differs from previous scholarship proposals. It is not a provision to aid needy students through medical school or to increase the number of students enrolled in all the schools. It is simply a plan to subsidize a number of students in return for a pledge to serve after graduation in the military establishments. As such, it is a business proposition between the student and the armed services. It is recommended that the establishment of such scholarships be endorsed, provided the following safeguards are imposed: (1) that the student not be approached until he is fully matriculated in the medical school; (2) that the student not expect nor receive special consideration so far as meeting the required standards of scholarship, behavior, and ethics are concerned, and that failure in these areas

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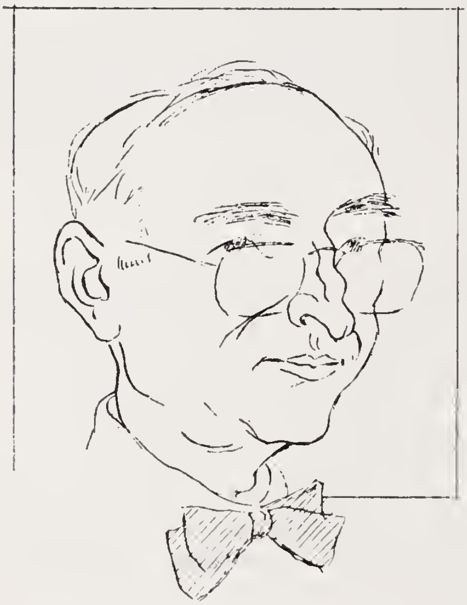
On the Lighter Side

Gervase J. P. Barger, M.D. is a remarkable man. He does things—active muscle things—at 72 years of age that many youngsters under 50 could not do without a guided course of professional training. His energy is amazing but his ambition is boundless. Not only does he climb mountains without effort and sprightly walks miles and miles of rugged trailways, but he actually took up serious social dancing at 69½ years of age and now flits about the dance floor with his charming wife—or some other feminine member of his dancing groups—in a tango, foxtrot, waltz, rhumba, samba, square dance, folk dance or what have you.



DR GERVASE J P BARGER
PHYSICAL MEDICINE

Dr. Barger has been a member of the Potomac Appalachian Trail Club since 1938. He started hiking (as a family) in Rock Creek Park when his youngsters were in their early teens, and as they grew older he added the more strenuous hikes on the Appalachian Trail in the Blue Ridge Mountains.

One of his special projects, designed to stimulate regular mountain hiking, was the making of an elevation profile of the trail from Harrisburg, Pa., to Waynesboro, Va., a distance of 260 miles. This completed graph of the trail is 45 feet long and gives a reasonably accurate facsimile of the ups and downs of this 260 miles of Appalachian Mountain trailway.

To complete this particular graph, Dr. Barger ambled to the mountains 26 times in 2½ years. Since then he has completed similar elevation profiles of some 60 other side trails. He has recorded over 1,300 measured miles on his measuring wheel since 1946, but this number represents only a small part of his actual hiking during that period.

To give you an idea of what Dr. Barger considers a normal week of routine hikes—he starts at daylight at one of the Rock Creek Park boundaries and, together with his wife, walks for an hour and a half before breakfast. This is no ordinary walk over the paved roads, oh no! Dr. Barger "bushwacks," as he terms it, climbing 3 to 5 hills in a morning's hike, or he follows the meandering roughness of the numerous valleys in the Park.

Five years ago Dr. Barger became restless after climbing all over the hills and valleys of Rock Creek Park, and he took up square dancing just to keep in trim. This form of exercise he has carried on regularly twice each month with his friends in the Potomac Appalachian Trail Club. In addition, in order to work out a few more muscles, he organized his own square dance group that "carries on," as he puts it, for two hours every Saturday night.

Two and a half years ago, at the fledgling age of 69½, Dr. Barger saw the value of social dancing as a recreation *and* as an exercise; therefore, he and Mrs. Barger enrolled in a dance studio in order to learn the steps from a "pro." His ability and aptitude were such that Dr. Barger was awarded a bronze certificate and medal of merit, and by June of this year he had attained the silver certificate and medal for specified excellence in tripping the light fantastic six different ways.

Now Dr. Barger does not rest easily on these laurels. In order to get in a little physical activity on the side he has rigged out a dancing room in his home where Mrs. Barger and the Doctor can practice daily; and, just to liven things up a bit, Dr. Barger has a weekly social dance party in his home to which he invites only skilled dancers. This, of course, does

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NEWSPAPERMEN AND DOCTORS*

BENJAMIN M. McKELWAY

Editor, The Evening Star, Washington

I am flattered by the invitation which brings me here this evening, although Mr. Wiprud left me with the impression that he was somewhat doubtful about the wisdom of the whole thing. It has not been customary, he said, to invite a newspaperman into these sacred precincts as a speaker; in fact, he thought this was the first time it had been done. I gathered his doubts were those of anyone who has arranged a highly dubious experiment.

The experiment is to put a newspaperman up here, in front of the doctors, tell him to open his mouth and say a-h-h, along with other sounds, and to see what happens, not only to the doctors but to the newspaperman.

The gracious invitation to participate in this experiment was accepted for two reasons:

The first is that a careful study of much of the propaganda—I mean literature—issuing from the medical men in the past few years has convinced me that medical progress depends, to a large extent, upon the use of live animals in medical research, regardless of whether they come from the city pound, or from Pennsylvania, or from *The Washington Star.*

Having espoused this cause editorially, receiving in return some harsh abuse from lovers of animals and cancellation of subscriptions from some former lovers of *The Star*, I decided it was time to look at the problem, or, rather, to look at the doctors, from the dog's point of view.

I already begin to understand how the dog must feel.

The other reason for acceptance of the invitation is a strongly personal—though largely sentimental—regard for the medical profession, which may spring in part from family associations and traditions.

The first of my forebears of the family name who came to this country was an immigrant from Scotland, who had received his medical education at the University of Edinburgh. He is reputed to have been a founder of one of the early medical societies in the United States, that of New Jersey.

I recently came into possession of a combined journal and account book he kept, listing the obstetrical cases he attended as a general practitioner from 1818 through 1866, in which are noted the departures from normal or items of special interest in each of the cases.

That diary contains evidence of medical progress. The first entries, written in a strong and beautiful Spencerian hand, noted that the charge for prenatal care and delivery was $4. Some 48 years later there is the final entry, in the quavering hand of old age. But the charge had risen to $10, an increase of 150 per cent.

Were this old grandfather alive today, I am sure he would have regarded with professional approval the even more extraordinary progress subsequently achieved by his brethren in this particular phase of medical practice.

The son of this immigrant was also a doctor. He was a surgeon in the Union Army at Gettysburg, and a letter he wrote home from the battlefield contained this passage: "Today I amputated the leg of General So-and-So. The operation should have been performed at the neck." His patient recovered, came to Congress, and for many years was a familiar figure in Washington, limping around town on his wooden leg. Having read of some of this man's exploits, I know what that grandfather was thinking about in his comment on the operation.

There have been doctors in numerous generations of my family, and those who did not go into medicine seem to have gone into the ministry or journalism. There is at least one common bond between these three callings. In each of them success for the practitioner depends, to an unusual degree, on the credulity of the human race.

I have a son who is about to start the practice of medicine. I hope that you will all come to know him and to split fees with him in ethical but equitable proportion. I am proud that he is a doctor. Of all the professions, I believe that the profession of medicine is the most authentic as to tangible and useful purpose and accomplishment.

I wanted to be a doctor myself. As a very young man, however, I witnessed an operation on a horse.

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* Presented at the Business Meeting of The Medical Society of the District of Columbia, March 3, 1954.

When I regained consciousness, I decided there must be other ways to earn a living.

I am glad I took up newspaper work, although I continue to believe that I could have cultivated an attractive bedside manner, and I still like to tell people what is wrong with them.

It may be that Mr. Wiprud and Dr. Ramsey hoped that as a newspaperman I would tell you what is wrong with the doctors, especially in their public relations, a field with which newspapermen are supposed to have some familiarity.

I really don't know much about public relations, which might be defined as the art of cultivating a relationship with the public designed to influence its good opinion.

An illustration of a sound sense of public relations, however, is contained in the story of a young Naval officer. One of the Roosevelt boys was having trouble with his public relations. He had brought a big dog home on a military plane from Europe just after the War, the dog's presence theoretically having deprived some service man of a seat in the airplane. The country, or at least the country's newspapers were exploiting the incident to the fullest degree. One of the functions of journalism, as you have doubtless heard, is to "comfort the afflicted, and to afflict the comfortable"—and this particular son of the Roosevelts was one of the more comfortable, until the incident of the dog and the bumped service man.

In the midst of the excitement over dogs riding in service airplanes, a young Naval officer, going home on leave, became conscious of the fact that the little dog he was taking to his children might be spotted at the airport and thus bring the Navy into disgrace for letting dogs, instead of service men, ride in airplanes. To make matters worse, when the officer reached his destination the little dog began to bark frantically.

Thinking only of the good name of the Navy, the officer buttoned the dog inside his coat, and descending from the airplane walked through the crowd, drowning out the noise of the smothered yelps of the dog by barking himself, at the top of his voice, thus preserving the good name and reputation of the United States Navy.

The story is helpful, because it contains the essence of good public relations.

I do not see why anybody in the medical profession should be much concerned over public relations. You have a sympathetic and even admiring newspaper press. You have a very efficient lobby, which has developed among the more conservative politicians and editorial writers a sort of conditioned reflex, with the result that when anybody, especially anybody like Oscar Ewing, makes some proposal regarding increased availability under Government auspices of medical care, the politicians and the editorial writers automatically utter warnings against the dangers of socialized medicine, although I don't believe many people really know what socialized medicine is, except that it must be pretty awful.

One picture of the medical profession which has become more or less fixed in the public mind shows, on the one hand, a group of dedicated and white-coated scientists, bending over test tubes and producing marvelous cures for various ailments, and, on the other, equally dedicated practitioners of medicine and surgery, devoting themselves to easing pain and prolonging human life, without thought of personal gain and at considerable self-sacrifice. That is a picture designed to win friends, and the newspaper press is largely responsible for painting it.

There are several things wrong with this picture, aside from its oversimplification. One thing wrong with it is that too many doctors seem to believe it themselves, and to the extent of a conviction that they, the doctors, can do no wrong. Another is that when some of the fallacies of the picture become obvious to the public, disillusionment is tinged with a bitterness which breeds public hostility.

The medical profession is becoming intelligently conscious of the dangers of creating in the public mind a false or misleading picture regarding its activities.

One of the interesting developments of recent years has been the organized effort, under leadership of the American Medical Association and local-minded societies around the country, to cultivate a relationship with the newspaper press that will be productive of greater understanding of the problems of the press by the doctors, and of the problems of the doctors by the press.

I do not take the dismal view that the objective of these efforts is purely selfish on the part of the doctors, or that they hope merely to gain in public esteem. The more likely objective is to prevent errors resulting from misunderstandings which may have the effect of placing both the medical profession and the press in a false light.

It has been said that a possibly cynical and definitely broad generalization, attributed to Sir William Osler, has influenced the attitude of many medical men toward the press. The statement was:

"Believe nothing you see in the newspapers. They have done more to create dissatisfaction than all other agencies. If you see anything in them you know is true, begin to doubt it at once."

It would be as great an error to believe that doctors have been strongly influenced in their attitude toward the press by Sir William's admonition as to believe that the press has accepted as the truth one of Voltaire's definitions of the physician, "A physician is a person who pours drugs, of which he knows little, into a body, of which he knows less."

There is an old rhyme that runs as follows:

> "When people's ill, they come to I,
> I physics, bleeds and sweats 'em;
> Sometimes they live, sometimes they die.
> What's that to I? I let's 'em."

But although those lines were written by a doctor, and even though they may contain more truth than poetry, they have not influenced in any discernible degree the thinking of the press toward the medical profession.

It is true, however, that doctors generally are suspicious of newspapers and newspapermen, and that while there are a lot of newspapermen, relatively few of them have any understanding of the doctors.

The doctors and the newspapermen inhabit different worlds. They look at the same thing, but from entirely different points of view.

To the doctor, something new is something untried, something of which little really is known, something to be very skeptical of until it has been proven to be what is claimed for it.

To the newspaperman, something new is news, to be rushed into print before the other fellow gets it into print. If there are to be fuller explanations, they can be made tomorrow.

To the doctor, the relationship with a patient is so personal and so sacred that it is given special dispensation in the law.

To the newspaperman, the news of what happens to almost anybody is public property, provided he can get his hands on it and it's fit to print.

The doctors are governed by a code of ethics, and an ancient oath, the need for which has been tested by centuries of experience. A violation of ethics or oath by a doctor can bring disgrace, and loss of license to practice.

Newspapers have codes of ethics, written and unwritten. The written code is not more than 30 years old, and many newspapermen have never seen a copy. The unwritten code is as elastic as the circumstances in which it may be invoked.

Newspapers are not licensed, nor are newspapermen, since such licensing would contradict the principle of freedom of the press written into the Constitution; therefore, a newspaper which violates an ethical code is subject to no penalty, unless the penalty is inflicted by the readers in their loss of confidence and the loss of their patronage.

In mentioning some of these fundamental differences, I am not praising the medical profession or disparaging the newspapers. The comparisons, in other words, are not intended to be odious. There are logical and sound reasons for the differences in concept and in practice between medicine and the press, for their separate functions are as far apart as the Poles.

I spoke earlier of the efforts under way, not to reconcile the differences between the practice of medicine and of journalism, for they cannot be reconciled, but to prevent some of the mistakes which result from lack of a mutual understanding of two sets of problems and motives.

Only within the past few days a meeting of Washington and Maryland newspapermen in Baltimore heard a panel discussion between doctors and newspapermen designed to throw more light on their conflicting points of view.

One of the doctors who took part in the panel discussion was your own President, Dr. Ramsey, and I was pleased to note that he spoke of the generally good relations between the Washington press and the Washington medical men. As a Washington newspaperman for more than 30 years, I share Dr. Ramsey's opinion.

Comparable meetings are being held all over the United States. Out of a few of them there have resulted "codes of coöperation" to govern the relationships between doctors and newspapermen. One such code operates in Denver. Another was only recently adopted in an Illinois county. There are doubtless others, applying in communities where the doctors and the newspapermen have decided to put down on paper the things that they can agree upon as helpful if adopted by both sides.

The codes are very simple, attempting merely to outline procedures mutually acceptable by the doctors and by the newspapermen in given situations. One provision is the designation, by the doctors, of spokesmen for the local medical fraternity, the object being to absolve the medical spokesmen of the suspicion by their brethren that they are seeking free advertising by being quoted in the press; and at the same time to let the newspapermen know of the approved sources of news concerning local medical activities.

Some attempt has been made in these codes to simplify for the newspapermen access to printable news from hospitals (the difficulty of obtaining such news being a sore spot with newspapermen), and to spell out the conditions under which such news may be expected to be given, and by whom.

The codes also seek to deal with the troublesome problem of preventing premature and misleading publication by newspapers of the efficacy of new drugs, or the success of new surgical and other medical technics, because such publication, as all doctors know, sometimes creates hopes which are apt to be false hopes. That is something of a national problem, incidentally, which is difficult to approach from a purely local angle.

A code was recently drawn up in New York State and presented to a meeting of the New York Society of Newspaper Editors in Buffalo. It met a completely hostile reception from the editors.

The New York "Code of Coöperation" on medical news seems to have been drafted experimentally by the New York State Medical Society. The extent of participation by newspapermen in preparing this draft is not known to me. Evidently, it was not sufficient. And obviously it did not reflect very sound advice.

The proposed New York code, for example, contained a clause saying that, when a doctor or hospital authority is quoted directly by name, "newsmen shall make certain to the best of their ability the quotation is accurate both in content and context."

We all know what the doctors were talking about. But the phraseology was unfortunate. The comparable implication would be found in a code for the doctors, drawn up by newspapermen, which declared that before operating on a patient, doctors must wash their hands and sterilize the instruments and take precautions, to the best of their ability, to see that the patient does not die from an infection induced by carelessness and dirt. The doctors would resent that provision in a code governing their relationship with newspapermen and consider it somewhat insulting.

Another proposed provision of the New York Code contained a differentiation between giving out news regarding the treatment of private patients, and the news of treatment of police-case patients. The newspapermen were unwilling to substitute the word of the doctor for the word passed out by the friendly cop, who is often the source of accurate, as well as uninhibited, information.

At any rate, the New York Society of Newspaper Editors turned the code down and gave the following reasons:

"a. No joint code of ethical procedures can be drawn to regulate the conduct of two groups in such unrelated fields of endeavor as the medical and journalistic professions.

"b. Neither profession can conscientiously submit to the effort of any other professional group to establish a code of conduct which will be binding upon it. Any such code must of necessity, to be effective, spring from voluntary action within the group itself.

"c. Nevertheless, appreciating the good will and coöperative spirit demonstrated by the appearance of spokesmen for the Medical Society of the State of New York, we hereby authorize the President of this Society to name a committee which will advise and counsel with the Medical Society at their call in the latter's efforts to clarify the relationship which should exist between the medical profession and the press.

"d. We urge that in such exchange of ideas the Medical Society fairly recognize at all times that the press itself is equally interested in health and humanity and can be trusted to safeguard such objectives by its own accepted ideals and principles of decency, good taste and honesty."

The codes are new, and they are somewhat suspect among newspapermen. That is one reason I hope that here in Washington we of the newspaper business and you of the medical profession will adopt a wait-and-see attitude while we observe the success or failure of the codes in other places. For until we know precisely what we want to accomplish in such a code, and understand as clearly what we do not seek to accomplish in a code, there is apt to be failure, and failure is sometimes prejudicial to later efforts.

One thing that we should understand is that "Codes of Coöperation" are not designed to keep things out of a newspaper because they may happen to be unpleasant reading for the doctors, individually or collectively.

I know that newspapers print completely accurate and factual news at times that doctors would prefer to see not printed. We also print news that politicians do not like to see printed, or that lawyers do not like to see printed, or that other classes of people do not like to see printed. They do not like to see it printed because the news may adversely affect their own selfish interests.

A good many people, including, perhaps, some doctors, have the very definite idea that newspapers deliberately suppress news at the request or the demand of people with influence who do not want to see the news printed. Undoubtedly that has been done, and undoubtedly, on some newspapers, it is done today. But news is not suppressed by any self-respecting newspaper that values its reputation, and it is not suppressed by anyone who has the right to call himself a newspaperman.

As ironical as it is, one of the surest ways to see that an objectionable piece of news finds its way into print is to make some effort to keep a piece of news out of the paper, especially if the effort to keep it out takes the form of threat of reprisal.

I am speaking particularly of news that originates from some official source and is a matter of public record. I suppose that every decent newspaper at times refrains from printing a piece of news that is without significance and is unimportant, except for the tragic effect of publication on some unfortunate person. But if the suppression of news serves some selfish purpose, decent newspapers do not suppress it.

I do not associate doctors in my mind with the class of people who seek to suppress news for selfish purposes. In fact, in many years on *The Star*, I cannot remember such a request from a doctor, although I may have forgotten some. But I do know that in some highly delicate fields, such as malpractice suits, in which an innocent doctor can be as readily injured as a guilty doctor can escape just punishment, there has been some disposition by medical groups to blame newspapers for this condition and to seek a remedy for a serious problem by persuading newspapers to adopt some course of action.

In my own opinion the press is not the proper place to apply the remedy, and those who may believe it is are proceeding on the basis of a faulty diagnosis as to where the trouble lies.

There is a widely held opinion that the newspapers are inaccurate in what they report. That opinion is too often justified, as any experienced newspaperman will admit. But the newspapers are surprisingly accurate in most of what they print, and the average person unfamiliar with newspaper production has no comprehension of the effort and the routine checks that go into the prevention of mistakes.

Let me call your attention, however, to one difference between our mistakes and a doctor's mistakes. When we make a mistake, we put it in type, print it at a speed of more than 40,000 papers per hour per press, distribute it to hundreds of thousands of readers as quickly as we can, and let them study it at their leisure.

When a doctor makes a mistake—well, you know as well as I do how completely it can be buried.

Codes or no codes, relationships between doctors and newspapermen are improving all the time. They are vastly better than they used to be, and the improvement is due more to the growing sense of public responsibility on the part of the newspapers than to anything initiated by the medical profession itself.

I want to pay a tribute in this connection to the wisdom of the District Medical Society in having obtained and in continuing to utilize the valuable services of Ted Wiprud. He is a man who lives between the devil and the deep, blue sea—and by the blue sea I mean, of course, the newspapers.

He understands the doctors and he understands the newspapers. The newspapers are making use all the time of his understanding of the doctors and his generally sound advice, and I hope the doctors are making equal use of his understanding of the newspapers.

Newspapers are handling medical news far more intelligently than they used to do. There are very few metropolitan newspapers in the United States which fail to assign news of medicine and doctors to some reporter who specializes in that type of news, and who thus develops a background of knowledge, acquaintanceship and interest in the subject.

I am glad *The Star* was among the first newspapers to realize the value of assigning a competent journalist to specialize on medical and scientific reporting. Many of you have known Thomas R. Henry, one of the pioneers in this field. The trail-blazing work in the past 30 years of men like Tom Henry of *The Star*, Lester Grant of the *Herald Tribune* in New York, Howard Blakeslee of the Associated Press, William Laurence of the *New York Times*, and others, accomplished two things. It convinced the newspapers of the value of medical reporting in which the doctors, as well as the public, place some confidence. And it has convinced the medical men, or at least a lot of them, that the newspapers can do a great deal in helpful interpretation of medical problems to the public, and that the greater the coöperation of the medical profession with newspapers seeking to do a sound job of reporting, the more beneficial the results.

Some years ago I attended a conference of the Nieman Fellows at Harvard University. Nieman Fellows are selected from among newspapermen for scholarships enabling them to spend a year at Harvard, taking any course of study, supervised or unsupervised, that appeals to them. Dr. Conant had invited a group of editors to examine the Nieman system, to review its experience, and to report to him their opinions as to how it was working out as an aid to the improvement of journalism. One of those whom we interviewed was the Dean of the Medical School, and to our surprise he turned out to be one of the most enthusiastic members of the Harvard faculty in his appraisal of the Nieman scholarship plan. A number of newspapermen were participating as observers in some of the medical school courses. The Dean said he welcomed them, and for this reason: If a newspaperman could learn, from even casual studies in the medical school, the rareness with which a single new truth is discovered in medicine, and obtain some comprehension of the labor, patience, imagination, vision and determination that enter into the discovery and verification of that truth, the Nieman Fellowships would be justified and would have accomplished their purpose.

I like to think that the newspapers, by and large, are beginning to share that concept of the medical profession's search for truth.

You are more disciplined in medicine than we are in newspaper work. You have established standards in education and training, of which there are no real parallels in journalism. You are accountable, not only to your patients, but to Government, which licenses you to practice medicine and which can withdraw that license. We are accountable, not to Government, but to the people, for if they do not approve of a newspaper they will not read it, and the newspaper will go out of business.

You police yourselves and your fellow practitioners, and cast out those who prove unworthy of their responsibility.

The idea of a policeman is repugnant to the idea of the free press; the only effective policeman for a free press should be the consciousness of public responsibility by newspapermen.

There are many other differences between us. But we should recognize that we have several things in common—a certain dedication to what we conceive to be the public interest, a pride in our professions, and a deep suspicion of Government encroachment on the freedom, initiative and imagination of the individual, on which true progress in medicine, as well as anything else, depends.

With such things in common, differences in our approach and points of view are surely worthy of our mutual study and understanding.

DR. HESS OF PENNSYLVANIA NEW PRESIDENT-ELECT OF AMA

At the 103rd Annual Meeting of the American Medical Association in San Francisco, June 21–25, Dr. Elmer Hess, of Erie, Pa., was named President-elect, to take office at the June, 1955 meeting in Atlantic City. Dr. Hess has served as a member of the House of Delegates of the AMA and as Chairman of the Council on Medical Service.

Dr. Walter B. Martin, of Norfolk, Va. assumed the presidency of the AMA at the inaugural session, June 22, in the Gold Ballroom of the Palace Hotel. His address on "Medicine and the Public Welfare" is available in pamphlet form from the Public Relations Department of the AMA.

Of the total registration, approximately 35,000, including 12,000 physicians, some 120 physicians were present from the District of Columbia. More than half of these were members of the District Medical Society. Dr. Herbert P. Ramsey, President of the Medical Society of the District of Columbia, Drs. Hugh H. Hussey and Raymond T. Holden, delegates to the AMA, and Mr. Theodore Wiprud, Secretary of the Society, were among those present from the District of Columbia.

Members of the Medical Society addressed four sectional meetings and presented a number of scientific exhibits. Dr. William P. Herbst spoke before the Section on Urology, June 23, on the subject, "Factors Involved in the Management of Prostatic Obstructions." Before the Section on Pathology and Physiology, the same day, Lt. Colonel Lorenz E. Zimmerman, MC, USA, presented a paper on "The Demonstration of Histoplasma and Coccidioides in So-called Tuberculomas of the Lung: A Preliminary Report on 35 Cases."

Major General Harry G. Armstrong, Surgeon General of the Air Force and Chairman of the Section on Military Medicine, opened the sectional meeting with the Chairman's address on "Military Medicine Today." Dr. Frank B. Berry, Assistant Secretary of Defense for Health and Medical Affairs, spoke on "Current Problems in Military Medicine." Both General Armstrong and Dr. Berry are Honorary members of the Medical Society. A paper on "Arterial Grafts in Military Surgery" was presented to the Section by Dr. Robert B. Brown, Bethesda, Md., and Dr. Charles A. Hufnagel, Washington.

Before the Section on Preventive and Industrial Medicine and Public Health, Dr. E. P. Luongo, of Los Angeles, an Associate member of the Medical Society, presented a paper on "Evaluation of Periodic Examinations of Employees." Dr. Fred L. Soper, Director of the Pan American Sanitary Bureau, described the functions of the International Health Organization.

Among discussants of papers at the scientific sessions were Drs. Francis M. Forster, James N. Greear, Jr., and Charles F. Geschickter.

ELMER HESS, M.D.
President-elect of AMA, 1954–55

CAT.

Scientific Exhibit Program

A special Question and Answer Conference on Cardiovascular Diseases was presented in coöperation with the American Heart Association. Dr. Charles A. Hufnagel, Assistant Professor of Surgery, Georgetown University School of Medicine, with Drs. John C. Jones and J. Francis Dammann, Los Angeles, discussed "The Treatment of Congenital Heart Disease," June 21. On June 22 Dr. Hufnagel, with Drs. Henry Haimovici and Ralph A. Deterling, New York, presented the topic, "The Treatment of Nonsyphilitic Aortic and Peripheral Vascular Disease." This conference, while not eligible for an award, was cited for its excellence by the Committee on Awards of the Scientific Exhibit.

Washington physicians were responsible for a number of scientific exhibits in the various sections. Of interest to Washington physicians were the following:

Section on Diseases of the Chest: "Surgical Treatment of Aortic Insufficiency," Drs. Charles A. Hufnagel, Pierre Rabil, W. Proctor Harvey, and John C. Rose, Georgetown University Hospital

Section on General Practice: "Medical Writing by the General Practitioner," Dr. I. Phillips Frohman. In view of his interest in writing, Dr. Frohman was invited to attend the meetings of the American Science Writers' Association

Section on Internal Medicine: "A simple Blood Prothrombin Test for the Control of Dicumarol Therapy," Dr. Benjamin Manchester, George Washington University School of Medicine

Section on Pathology and Physiology: "Histopathologic Effects of Plasma Expanders," Drs. Hans F. Smetana and Frank B. Johnson, Armed Forces Institute of Pathology. This exhibit received Honorable Mention.

Section on Physical Medicine and Rehabilitation: "Evaluating the Patient's Abilities," Drs. A. B. C. Knudson, Joseph Van Schoick, and Thomas J. Zwierlein, Veterans Administration

Section on Preventive and Industrial Medicine and Public Health: "Maintenance for the 'Whole' Man—A Broad Concept of Preventive Medicine in Industry," Dr. E. P. Luongo, General Petroleum Corporation, Los Angeles

Section on Radiology: "Resilient Plastic Replicas of Surgical Pathology and Their Clinical Application," Drs. Clemmer M. Peck, Forrest V. Schumacher, Aubrey O. Hampton, Emergency Hospital, and Dr. John V. Niiranen, USN, Washington. This exhibit was awarded a Certificate of Merit.

Section on Surgery, General and Abdominal: "Reconstructive Arterial Surgery," Drs. Pierre Rabil and Charles A. Hufnagel, Georgetown University Hospital

Miscellaneous Exhibits: "Breath Sounds on Tape," Drs. R. J. Anderson and Armand E. Brodeur, U. S. Department of Health, Education and Welfare, Public Health Service, and Dr. William B. Walsh, Georgetown University School of Medicine; this exhibit received Honorable Mention; "Nursing Service," Dr. David N. W. Grant, American National Red Cross

Medical officers of Walter Reed Army Medical Center were recognized by a Certificate of Merit for their exhibit on "The Initial Management of the Severely Wounded" and by Honorable Mention for their exhibit on "Arteriography in Vascular Injuries."

Dr. Francis M. Forster, Dean of Georgetown University School of Medicine, served on the Committee on Awards of the Scientific Exhibit.

CONFERENCE OF PRESIDENTS AND OTHER OFFICERS

Dr. Louis M. Orr, Orlando, Fla., President of the Conference of Presidents and Other Officers of State Medical Associations, presided at the 10th Annual Conference, which was held in the Palace Hotel, June 20. Theodore Wiprud, Secretary-Treasurer of the Conference, presented the financial report. He was elected to the Executive Committee for 1954–55.

In a Panel Discussion on Doctors and the Press, President Ramsey of the District Medical Society gave the physician's point of view, while Steven M. Spencer, Associate Editor of the *Saturday Evening Post*, presented the magazine editor's point of view, and Mr. Alton L. Blakeslee, of the Associated Press, the science writer's viewpoint.

CITATION TO SMITH, KLINE AND FRENCH

For "pioneering use of television in bettering the health of the Nation," President Martin of the AMA conferred a special citation on Smith, Kline & French Laboratories, of Philadelphia. Mr. Francis Boyer, President of the firm, accepted the plaque from Dr. Martin at the presentation ceremony in the House of Delegates meeting, June 24. This award was the first ever made by the AMA to a commercial house.

The first transcontinental color medical telecast in history was seen by physicians attending this convention. A four-day program on cancer, entitled "Tumors of the Kidney," originated in the Memorial Hospital of New York City and was transmitted over a closed circuit to San Francisco. The program was presented through the coöperative efforts of Smith, Kline & French, the American Cancer Society, and the Columbia Broadcasting System.

NEW APPOINTMENTS AND OTHER NEWS

Dr Frohman was elected Vice Chairman of the Section on General Practice of the AMA.

At the Medical Society Executives Conference, June 21, Mr. Wiprud was elected to the Executive Committee.

Dr. William B. Walsh assumed the presidency of the National Medical Veterans Society at its annual meeting in San Francisco, June 22.

At the annual meeting of the American College

(*Continued on page 474*)

News and Personals

MEETINGS—Past and Future

The Second World Congress of Cardiology and the 27th Annual Scientific Sessions of the American Heart Association will bring to Washington, September 12–17, 1954, outstanding speakers of the profession from all parts of the world. Dr. Paul D. White, of Boston, President of the Congress, will open the scientific sessions on Monday, September 13, at 9 a.m., in the Main Auditorium of the National Guard Armory. All physicians are invited to attend.

Members of the Medical Society will receive in the mail a complete copy of the scientific program. In this issue of the ANNALS is a brief editorial by Dr. Hugh H. Hussey, giving some of the unique features of the meetings and listing a few of the social events.

Local arrangements for the meeting are being made by the Washington Committee on Arrangements, of which Dr. Bernard J. Walsh is Chairman. He is assisted by Drs. Clayton B. Ethridge, W. Montague Cobb, William R. Haas, Henry Cooper, Thomas W. Mattingly, and Charles R. Meuller.

The 32nd Annual Scientific and Clinical Session of the American Congress of Physical Medicine and Rehabilitation will be held, September 6–11, 1954, at the Hotel Statler, Washington. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

At its annual business meeting, May 10, **the Washington Academy of Surgery** elected Dr. W. Ross Morris as President for the coming year. Dr. Harry Lee Claud is the new Vice Preisdent. Dr. Duane C. Richtmeyer will serve the second of his two-year term as Secretary-Treasurer.

Four scientific meetings are scheduled for 1954–55. These will be dinner meetings for members and their guests at the Kennedy Warren, beginning at 7 p.m. Guest speakers will be announced later in the year. The scheduled dates are October 11 and December 13, 1954, February 14 and April 11, 1955.

The Washington Heart Association held its annual meeting and election of officers in the Medical Society's building, June 14. Dr. John A. Reisinger was elected President, succeeding Dr. Clayton B. Ethridge, who has served in this capacity for the past two years.

Dr. Ethridge was presented with the "Hercules Heart" for services to the Association. Other recipients of the award were E. Cleveland Giddings, Campaign Chairman for the 1954 Heart Fund; H. Chapman Rose, Chairman of the Federal Employees' Committee of the 1954 Heart Fund; Mrs. C. Thomas Clagett, Board member and Chairman of the Speakers' Bureau; Edward T. Stafford, General Business Chairman for the 1954 campaign; and Oscar H. West, Chairman of Public Relations for the campaign.

Dr. West was elected Vice President of the Association and Mrs. Clagett, Secretary. Mr. Kenneth Birgfeld was reëlected Treasurer.

Among those elected to the Board of Directors for a three-year term was Dr. John M. Evans. Dr. W. Proctor Harvey was elected to fill a vacancy on the Board and will serve for two years. Drs. William L. Howell, John W. Latimer, Jr., and Benjamin Manchester were reëlected for three-year terms.

The Section on Otolaryngology of the Medical Society of the District of Columbia held a scientific meeting and election of officers at the Army-Navy Club on May 19. Dr. Gordon Bell gave a talk on "Plastic Reconstruction of the Ear." At the business session following the scientific program, the following officers were elected for 1954–55:

Dr. Willard B. Walters, *Chairman;* Dr. J. L. Levine, *Vice Chairman;* Dr. Russel S. Page, Jr., *Secretary;* and Dr. James J. McFarland, Jr., *Treasurer.*

This was the last meeting of the season. The next meeting will be held in the early fall.

The District of Columbia Society of Anesthesiologists elected the following officers, whose year of service began July 1:

Dr. Robert R. Cross, *President;* Dr. Charles S. Coakley, *Vice President;* Dr. William H. Devlin, *Secretary-Treasurer.*

Drs. Frank J. Grabill and Ervin N. Chapman were elected delegate and alternate delegate, respectively.

Drs. Cross, Coakley and Devlin will each serve the Section on Anesthesiology of the District Medical Society in the same official capacity.

The Clinical Section of the Diabetes Association of the District of Columbia held its last meeting of the season, June 9, at the home of Dr. A. Owen Penney. The following officers were elected to serve for the coming year:

Dr. Samuel Loube, *President;* Dr. James Moss, *Vice President;* Dr. Aaron G. Saidman, *Secretary-Treasurer.*

Dr. Russell J. Fields has been elected President of the **Social Hygiene Society,** succeeding Dr. William P. Herbst, who has served as President for the past several years. Albert W. Atwood was chosen First Vice President; Mrs. Leo Raywid, Second Vice President; Victor H. Evjen, Treasurer; and Mrs. Maurice H. Friedman, Secretary. **Dr. Helen Gladys Kain** was reëlected to the Board of Directors.

New officers of the **Providence Hospital Alumni Association** are:

Dr. Frank S. Pellegrini, *President;* Dr. Jean E. Paquin, *Vice President;* Dr. Thomas E. Curtin, *Secretary;* Dr. Vincent DiFrancesco, *Treasurer;* Dr. Charles F. Hill, *Historian.*

Dr. Karl Hayden Wood assumed the presidency of the **District Dental Society** at its meeting in the Shoreham Hotel, June 8. New officers elected at the meeting were:

Dr. J. Garrett Reilly, *President-elect;* Dr. Samuel A. Leishear, *Vice President;* Dr. Z. Bernard Lloyd, *Secretary;* Dr. Edward D. Leifer, *Treasurer.*

Dr. Reilly will assume the office of President in 1955.

GENERAL NEWS

Physicians may secure copies of the **Hand Talking Chart for aphasic patients** without cost from Dr. Hamilton Cameron, who developed it for his own use and who is distributing it for use by affected persons as a philanthropic contribution. In 1943 Dr. Cameron was stricken by coronary thrombosis, followed by cerebral embolism, which resulted in right hemiplegia and "complete" aphasia.

In his first four weeks, while in the hospital, Dr. Cameron visualized and devised the chart, which consists of 20 hand signs. It was $2\frac{1}{2}$ years later before he was able to express himself orally and have an artist make the drawings. By means of these signs, which require the use of only one hand, stroke victims affected by "complete" aphasia, also accident victims and hospitalized aphasic veterans, can communicate with those around them, thus making their wishes and basic needs known. The signs are simple and easily demonstrated. This method can be used in all speechless cases where the teaching of a complicated hand-sign language is impractical or impossible.

Copies of the Hand Talking Chart may be obtained from Dr. Cameron, 601 West 110th Street, Suite 3LL, New York 25, N. Y.

Announcement has been made of a number of promotions in the medical staff of **George Washington University School of Medicine.** Dr. George Nordlinger is now Clinical Professor of Obstetrics and Gynecology.

Professors raised from Assistant to Associate rank include: Dr. Samuel M. Dodek, Associate Clinical Professor of Obstetrics and Gynecology;

Dr. Walter H. Gerwig, Associate Clinical Professor of Surgery; Dr. Clarence R. Hartman, Associate Clinical Professor of Medicine; Dr. Vincent M. Iovine, Associate Clinical Professor of Surgery; and Dr. Leon Yochelson, Associate Clinical Professor of Psychiatry.

Georgetown University School of Medicine was granted a sum of $3,348 by the American Urological Research Foundation, Inc. to be used for a study of the relation of the endocrine system to renal calcification by Dr. Roger Baker, Professor of Urology.

The American Urological Research Foundation was organized and received its first charter in April, 1952, and is devoted exclusively to research dealing with the problems relating to disorders involving the kidneys, bladder, prostate gland and genitalia. The sum given to Georgetown was part of a total grant of $35,000 distributed among various teaching and research institutions.

A grant of $12,573 to **George Washington University School of Medicine** from the U. S. Public Health Service will be used to investigate the possibility that the bacteria associated with certain types of ulcerative cancers may contribute to the spread of those cancers within the body. Dr. Calvin T. Klopp, Director of the Cancer Clinic, and Dr. Angus M. Griffin, Professor of Bacteriology, will direct the research, assisted by Dr. Rudolph Hugh, recently appointed Assistant Research Professor of Bacteriology.

PERSONALS

EDGAR P. COPELAND, M.D.
Chief of Medical Staff Emeritus, Children's Hospital

Dr. Edgar P. Copeland has resigned as Chief of the Medical Staff at **Children's Hospital,** to become Chief of Staff Emeritus, but he will also continue to be active on the staff and the hospital will benefit from his 50 years' association with it.

In 1941 Dr. Copeland was elected Vice Chairman of the Medical Staff. This office was maintained until September, 1952, when he became Chief of Staff upon the death of Dr. Joseph S. Wall. He is Chief Pediatrician at Columbia Hospital for Women and Doctors Hospital and Consulting Pediatrician at St. Ann's Infant Asylum.

Dr. Hugh J. Davis, who has served as Vice Chairman of the Medical Staff, assumed the duties of the Chief of the Medical Staff on June 14.

Dr. John P. McGovern has accepted a full-time position as Associate Professor of Pediatrics at Tulane University in New Orleans and assumed his new teaching and research duties on August 1.

For the past 4 years Dr. McGovern has been on the teaching staff of George Washington University School of Medicine as Assistant Professor of Pediatrics and as a John and Mary R. Markle Scholar in Medical Science. He was also Chief of the George Washington University Pediatrics Division of the D. C. General Hospital and Associate Attending Physician on the staff of Children's Hospital. In addition to his teaching and research duties, Dr. McGovern maintained an office for private practice of pediatrics at 4801 Connecticut Avenue, N.W. He will complete his Markle scholarship at Tulane University.

CAT.

DR. CARTER HONORED BY EASTON (MD.) MEMORIAL HOSPITAL

DR. HILL CARTER (right) accepting inscribed tray from DR. WILLIAM T. HAMMOND, of the medical staff of Memorial Hospital, Easton, Md., in recognition of his 17 years of service as consultant to the Hospital.

Dr. Hill Carter was the guest of honor at a testimonial dinner at Tidewater Inn, Easton, Md., June 17, upon his retirement as consultant to the Memorial Hospital at Easton. Members of the medical staff, the Board of Directors, and their wives, about 150 in number, were present for the occasion. Special guests from Washington were Mrs. Carter and Dr. William Earl Clark, senior member of the group of physicians with whom Dr. Carter is associated in the practice of internal medicine at 1835 Eye Street, N.W.

Dr. Carter has held monthly clinics at Memorial Hospital in Easton for 17 years, beginning in 1937. In recognition of his services, he was presented with an inscribed silver tray in behalf of those present by Dr. William T. Hammond.

Dr. Herbert P. Ramsey, President of the Medical Society of the District of Columbia, **and Dr. Fred L. Soper,** Director of the Pan American Sanitary Bureau, were two of the guest speakers at the 53rd Annual Meeting of the Medical Library Association at the Hotel Statler, June 15–18. The theme of the convention, which boasted a registration of 400 medical librarians, was Medical Research.

Dr. Ramsey spoke on "Washington as a Medical Center" on the opening day, June 15. Dr. Soper was moderator at the afternoon session, which concerned "International Aspects of Medical Research." At an inaugural luncheon the same day, Dr. Ramsey, Dr. Soper, Dr. W. Montague Cobb, Editor of the *Journal of the National Medical Association*, and Dr. Joseph L. Johnson, Dean of Howard University School of Medicine, were among the distinguished guests.

Major General George E. Armstrong, Surgeon General of the Army, attended a special meeting in the office of Major General Georges André Hugonot, Surgeon General of the French Army, in Paris, May 14, where he was requested to accept the Medaille d'Honneur du Service de Sante Militaire for seven U. S. Army Medical Service personnel who had rendered outstanding services to the wounded and sick of the French Battalion in the Korean campaign.

Those cited were Major General William E. Shambora, Brigadier General L. Holmes Ginn, Colonel Charles L. Kirkpatrick, Lt. Colonel William S. Bagnall, Colonel Vinnie H. Jeffress, Colonel William J. Moreland, and Captain Mary H. Jeffress.

General Armstrong also accepted a Gold Medal in behalf of **Dr. Melvin A. Casberg,** until recently Assistant Secretary of Defense (Health and Medical).

Dr. Frank D. Costenbader gave the Annual Alumnus Address at the Annual Meeting of the University of Virginia Medical Alumni Association in Charlottesville, Va., June 11. Dr. Costenbader, a member of the 25-year Class, entitled his address, "Fifteen Years of Pediatric Ophthalmology." Dr. Costenbader is on the staff of Episcopal Eye, Ear and Throat Hospital and Children's Hospital.

Dr. Donald Stubbs, head of the Department of Anesthesiology, Doctors Hospital, was guest lecturer at the 20th Annual Meeting of the Postgraduate Medical Assembly of South Texas, which was held at the Shamrock Hotel in Houston, July 19 to 21. Dr. Stubbs presented four papers: "Shock—Cardiac Arrest," "Respiratory Emergencies—Resuscitation," "The Management of Pain," and "Relation of Anesthesiology to Safe Surgery."

Dr. William P. Herbst gave a paper on "Physiology of the Kidney" as part of a Symposium on Physiology at the Genito-Urinary Surgeons 65th Annual Meeting at Shawnee-on-Delaware, Penna., May 26, 27 and 28.

Dr. Jeanne C. Bateman, who is affiliated with the George Washington University Cancer Clinic, attended the Sixth International Cancer Congress in Sao Paulo, Brazil, and presented a paper before the Congress, July 22, entitled, "Cancer Chemotherapy." Dr. Bateman made the trip by plane. Following the Congress, she was planning to visit Rio de Janeiro and cities in Peru, returning to Washington on August 12.

Dr. Irving B. Brick, Associate Professor of Medicine, Georgetown University School of Medicine, has been invited to present a paper on "The Management of Esophageal Varices in Cirrhosis of the Liver in the Absence of Gastrointestinal Hemorrhage" in Barcelona, Spain, October 6. The occasion is the Third International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians under the patronage of the Spanish Government. The meeting will extend from October 4 to 8, 1954.

Dr. Walter A. Bloedorn, Dean of George Washington University School of Medicine, was in New York, June 21, where he addressed the first session of the annual meeting of the American College Public Relations Association. Dr. Bloedorn's topic for discussion was "Public Relations in a School of Medicine."

Dr. Sol Katz, Chief of the Division of Pulmonary Diseases of the District of Columbia General Hospital, attended the annual meeting of the American Trudeau Society, which was held in Atlantic City, New Jersey, May 17–21, and participated in a panel discussion on sarcoidosis.

Dr. Edward P. Luongo, an Associate member of the District Medical Society, gave an address before the Pacific Northwest Industrial Health Conference at the Multonomah Hotel in Portland, Oregon, September 20–21. Dr. Luongo, who is Medical Director of the General Petroleum Corporation, Los Angeles, Calif., spoke on "Role of Plant Medical Department."

Dr. Robert H. Barter, Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine, discussed "Obstetric Emergencies" before the annual meeting of the Obstetrical Staff of The Hospital for the Women of Maryland in Baltimore, June 18.

Drs. Jean E. Paquin, Josephine E. Renshaw, Wallace H. McCune and Louis H. Moody, Jr., have recently qualified as diplomates of the American Board of Obstetrics and Gynecology. They were certified by the Board, May 17, at the Edgewater Beach Hotel, Chicago. Drs. McCune and Moody are Associate members of the D. C. Medical Society.

Major Phillip A. Cox, an Active member of the District Medical Society, and Lt. Colonel Kryder E. VanBuskirk, of Silver Spring, Md., were among 74 physicians and dentists graduated, June 18, from residencies and internships at the Walter Reed Army Medical Center. Major General Leonard D. Heaton, Commanding General of the Center, presided and presented diplomas to the officers in special ceremonies at the Center, June 22. **Dr. Frank Berry,** Assistant Secretary of Defense, delivered the graduation address.

Dr. J. Ross Veal has been appointed by the Washington Board of Trade to fill the unexpired term of the late A. W. Lee on the Board of Directors.

Dr. Eugene J. McDonald, Chief Radiologist at the Columbia Hospital for Women, was elected President of the Boston College Club at a meeting, June 23, in St. Patrick's School Hall. Dr. McDonald was graduated from Boston College in 1933.

Dr. Edmund Barry, a Life member of the District Medical Society, was remembered on his 90th birthday by the Society with greetings and flowers. He lives at 1844 Columbia Road, N.W.

Dr. Barry is a graduate of Columbian (now George Washington) University, a member of the class of 1891. He is a native Washingtonian and has practiced medicine in the District of Columbia since 1892. A veteran of the Spanish-American War, he served as Acting Assistant Surgeon of the U. S. Army from 1898 to 1904. During the World War I he was a member of the Board of Examiners. From 1905 to 1914 he was a member and President of the Board of Police and Fire Surgeons.

John J. Anderson, Administrator of Arlington Hospital, received the first Welburn Award from the Arlington County Medical Society, June 10. The Welburn Award was established this year in honor of Dr. W. C. Welburn, County Medical Examiner and a general practitioner in the County for more than 50 years. It was presented to Mr. Anderson at the annual dinner-dance of the Society at the Washington Golf and Country Club because of his "outstanding service in developing and enlarging Arlington Hospital during the past six years."

Dr. William E. Nessell has accepted a position as Medical Director of the Plastics Division of the Monsanto Chemical Company in Springfield, Mass. He is transferring his membership to the Massachusetts Medical Society, Hampden District, Springfield.

Dr. Thomas J. O'Connor is moving from Washington to New Jersey to resume his residency training in internal medicine. His address is 49 Concord Avenue, Glen Rock, New Jersey.

Dr. J. D. Giorgia, an Associate member of the District Medical Society, has resigned from the Navy and will practice anesthesiology in Indiana. His new address in 1018 Lincoln Avenue, Evansville, Ind.

Dr. William P. Hynes, formerly of Oceanside, Calif., has returned to Washington. His address is 3100 Connecticut Avenue, N.W., North Cathedral Mansions, Apartment 212.

CORRESPONDENCE

WASHINGTON, D.C., June 20, 1954

TO THE EDITOR:

With respect to the recent Chest X-Ray Survey conducted by the District of Columbia Tuberculosis Control Association, I beg leave to make a few constructive criticisms; but first, let me emphasize that I am heartily in favor of such surveys and that I find no fault with the personnel with whom I had contact. I believe they are doing a very good job and that their manners and attitude toward the public are impeccable.

I had my small film X-ray on May 27 and was called out for a large film retake on June 4. I took a half hour out from work and went to the Society headquarters, where I was well treated and got the business over with in good time. But—and here is my beef—one of the questions I was asked was whether or not I had any symptoms—and this, not by a doctor, but by a reception clerk. Then I was told that if I did not hear from them within two weeks I was to come back to the Society headquarters on June 18 and was given an appointment card to that effect. No word came. So, on June 18, after two weeks of wondering what was up, I again went to the Society headquarters. After a half hour's wait, I was taken into a cubicle by a doctor who showed me my film, the retake, and said it was entirely negative. I was greatly relieved, to say the least!

In my opinion, the whole process is very bad psychology. First, the time between the first and second X-ray examinations, or between small and first large films, could have been cut to about 3 days, but I daresay the personnel shortage at the Society would account for this. Second, the time between the large film retake and the second visit to the Society headquarters was inexcusable and unnecessary. The question as to whether I had any symptoms was uncalled for and would be damaging to anyone's morale.

I would suggest, instead, that the Society in the future notify persons by mail, as promptly as possible, that their retake films were negative or positive, as the case may be. It would save a lot of worry and spare the doctor a great deal of work too. I would suggest further that the chest X-ray retake, if positive, be sent to the patient's designated family doctor, who is the person to handle its disposal. To a layman, an explanation of an X-ray film of his own body by a strange doctor might be downright repulsive. There are not many laymen who could grasp the significance of the shadows pointed out to them so abruptly.

With all due respect and with best wishes for the continued fight against tuberculosis, I am,

Sincerely yours,
Warren L. Armstrong

Editor's note: A copy of the above letter was sent to the D. C. Tuberculosis Association and was returned with the following comment:

The operation of the mobile unit offering chest X-ray surveys in neighborhoods throughout the city is the joint effort of the D. C. Department of Public Health and the D. C. Tuberculosis Association. The responsibilities of each of these groups in this venture are well defined. The Association is responsible for community organization, locations of the mobile unit, and all procedures up to the taking of the 17 mm. film. The Health Department reads all films, notifies all who have had chest X-rays as to the results of their pictures, and does any follow-up work necessary at the C Street Clinic. Thus far this year, more than 35,000 chest X-rays have been made by the mobile unit. No report on the over-all results of the survey have been made available.

BOOKS RECEIVED

Acknowledgment is made of the following books which have recently been received. Selections will be made for more extensive review in the interests of our readers and as space permits. Physicians are urged to submit reviews of additional current books which, in their opinion, merit comment.

Progress and Problems in Mental Hospitals: Proceedings of the Fifth Mental Hospital Institute held under the auspices of the American Psychiatric Association Mental Hospital Service, Hotel Marion, Little Rock, Arkansas, October 19–22, 1953. Prepared for publication by Daniel Blain, M.D., Medical Director, A.P.A., Editor, and Stella B. Hanau, Consultant Editor. Price, paper, $2.50. Pp. 204. Washington, D. C.: American Psychiatric Association.

New and Nonofficial Remedies. Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1954. Issued under the direction and supervision of The Council on Pharmacy and Chemistry of the American Medical Association. Price, $2.65. Pp. 609. Philadelphia: Lippincott, 1954.

Beyond the Germ Theory—The Roles of Deprivation and Stress in Health and Disease. A New York Academy of Medicine Book. Iago Galdston, M.D., Editor. Price, $4.00. Pp. 182. New York: Health Education Council, 1954.

The Deaf and Their Problems. A Study in Special Education. Kenneth W. Hodgson, M.A., (Cantab.) with a preface by Sir Richard Paget, Bart., Fellow of the Physical Society, etc. Author of "Human Speech." Price, $6.00 Pp. 364. New York: Philosophical Library, 1954.

A Handbook of Resources Available to Physicians. With an appendix containing a summary of Sections of the Code of Iowa and the Rules of the Department of Health Governing the Practice of Medicine. Prepared for the members of the Iowa State Medical Society by its Committee on Medical Service. Pp. 127. March 15, 1954.

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis for 1953, Volume XIV, Parts I and II. Publication No. 33 0. New York: National Foundation for Infantile Paralysis, 1953.

Index—Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis 1939–1951. Publication No. 33 N. Pp. 206. New York: National Foundation for Infantile Paralysis, 1954.

The History of the Medical Department of the United States Navy in World War II; A Narrative and Pictorial Volume. Foreword by Ross T. McIntire, Vice Admiral (MC), U.S.N. (Retired) and Bennett F. Avery, Captain (MC), U.S.N., Editor. NAVMED P-5031, Volume 1. Pp. 380. Washington, D. C.: U. S. Government Printing Office, 1953.

Syllabus of Medical Mycology. Raymond Allen Osbourn, B.S., M.D., Assistant Professor of Mycology, Clinical Assistant Professor of Dermatology and Syphilology, Georgetown University School of Medicine, Washington 7, D. C. Price, paper, $1.50. Pp. 25. Washington, D. C.: Author, 1954.

Ciba Clinical Symposia. Volume 5, Numbers 1–6. Containing: Selected Dermatoses Seen in General Practice; Disorders of the Hip; Pathology of the Mouth and Jaws; Venous Disorders of the Lower Extremity; X-Ray Examination of the Chest and Its Surgical Significance; and Disorders of the Knee. J. Harold Walton, M.D., Editor, Richard H. Roberts, M.D., Associate Editor, and John N. Kolen, Production. Pp. 201. Summit, N. J.: Ciba Pharmaceutical Products, 1953.

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S. ARTHUR LINDE, M.D.

(1902–1954)

Dr. S. Arthur Linde, Washington surgeon and proctologist, died, June 19, 1954, in Doctors Hospital, following an illness of several months. He established his office in the Columbia Medical Building in Washington in 1941, limiting his practice to proctology, later moving to 915 19th Street, N.W. He resided at 3051 Idaho Avenue, N.W.

Born in New York City, December 17, 1902, Dr. Linde moved to Baltimore as a young man and received his education in Maryland schools. He attended Baltimore City and Mt. Vernon colleges and graduated in medicine from the University of Maryland in 1925. He took his internship and resident training at Sinai Hospital in Baltimore, 1924 to 1929, specializing in surgery and coloproctology. He also took postgraduate study in his specialty under Dr. Harry E. Bacon of Temple University. He was a member of the executive and teaching staff of Doctors Hospital and Associate Chief of Coloproctology of Doctors Hospital.

Commissioned Lt. Commander of the U. S. Navy in World War II, he served as proctologist on the medical staff of the Norfolk Naval General Hospital.

Dr. Linde was Associate Editor of *Proctology*. He contributed a chapter on Diverticulitis in Bacon's book on "Diseases of Anus, Rectum and Colon," published in 1949, and wrote articles in his field for other medical journals.

Dr. Linde was Vice President and President-elect of the Philadelphia Proctological Society; he was a Fellow of the International College of Surgeons and the American Proctological Society, and a member of the American Medical Association, the Jacobi Society of Washington, and the Phi Delta Epsilon medical fraternity. He had been an Active member of the District Medical Society since 1942.

As a hobby, Dr. Linde was interested in portrait painting. One of his works hangs in the Philadelphia Medical Museum.

He is survived by his wife, Mrs. Jeanette R. Linde; a son, Barrett M. Linde, living at home; and a sister, Miss Selma Linde, of Washington.

HARRY HURTT, M.D.

(1873–1954)

Dr. Harry Hurtt, a Life member of the Medical Society of the District of Columbia, and a practicing physician in Washington for more than 50 years, died, June 25, 1954, at his country home near Still Pond, on the Eastern Shore of Maryland.

Dr. Hurtt lived all his life in and near Washington. He was born, February 22, 1873, in Kennedyville, Kent County, Maryland, not far from the home where he died. His parents were James W. and Mary Woodland Hurtt.

Educated in private schools on the Eastern Shore, Dr. Hurtt was graduated from Washington College, Chestertown, Md., in 1892. He received his degree in medicine from the University of Maryland in 1895, and interned at the University of Maryland Hospital. During his year of internship he also studied under Dr. Welch at Johns Hopkins University. He was licensed to practice in Maryland in 1895 and in the District in 1897.

Dr. Hurtt became a member of the Medical Association of the District of Columbia in 1899, of the District Medical Society in 1900, and a Life member of the latter in 1940. He was a member of the American Medical Association, a charter member of the University Club, and a member of the Alumni Clubs of the University of Maryland and Washington College.

His last residence in Washington was at 1765 R Street, N.W. He left the city for his home in the country five years ago. Surviving him is his wife, Mrs. Millicent Beard Hurtt.

VIRGIL HEATH CORNELL, M.D., Dr.P.H., F.A.C.P.

(1890–1954)

Colonel Virgil H. Cornell, who was Chief of the Laboratory Service at Walter Reed Army Hospital when he retired from the Army in 1950, died, June 3, 1954, at his home, 1376 Locust Road, N.W.

Since his retirement, Colonel Cornell had been pathologist for the Washington Sanitarium in Takoma Park and Professorial Lecturer in Pathology at George Washington University. He had a clinical laboratory at 705 Prince Street, Alexandria.

Born in Brooklyn, New York, in 1890, Colonel Cornell secured his medical degree from Long Island Medical College in 1913 and his Doctor of Public Health degree from Harvard. He was assistant physician and pathologist at Essex County Hospital, Cedar Grove, N. J., before he began his Army career in pathology.

Colonel Cornell was Curator of the Medical Museum of the Armed Forces Institute of Pathology from 1933 to 1935. From 1941 to 1943 he was Director of the Caribbean Area Laboratory and then was Commanding Officer of the 15th Medical General Laboratory. He set up two blood banks for the Mediterranean and Southern France theaters, using C-47s to ship blood direct to the front lines. For this he received the Legion of Merit.

He was a member of the American Medical Association, a diplomate of the American Board of Pathology and the American Board of Preventive Medicine and Public Health, and a Fellow of the American College of Physicians and the American College of Pathology. He was the author of various medical articles.

Surviving is his wife, Mrs. Ruby Cornell, whom he married in 1916.

Micrococcal Enterocolitis—Martin, Nichols and Geraci

(*Continued from page 422*)

antibacterial agents. Then growth of strains of *M. pyogenes* (staphylococci) which are resistant to the agents is unopposed. The micrococci may produce such severe systemic reactions that time must not be lost in recognition of the syndrome. The condition is potentially fatal. The presence of innumerable gram-positive cocci in smears and their existence in practically pure culture in the stools confirm the diagnosis. In severe cases prompt use of an antibiotic to which the micrococci are sensitive is imperative.

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Fear and Phobias—Laughlin

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Delegates' Report on AMA Meeting

(*Continued from page 455*)

shall automatically terminate the scholarship arrangement with the student; and (3) that the total number of students on such scholarships in any year's class in all of the schools and the number in a class in any single school shall not exceed 5 per cent."

Respectfully submitted,
Hugh H. Hussey, M.D., *Delegate*
Raymond T. Holden, M.D., *Delegate*
Theodore Wiprud, *Secretary*

On the Lighter Side—Kadan

(*Continued from page 456*)

not interfere with the Saturday night affairs for square dancing only.

To flex his muscles a wee bit more, Dr. Barger has undertaken *two* weekly folk dance classes under expert tutelage, and by pinning him down, Dr. Barger admits that of all the dances, folk dancing is the most strenuous. However, he says, also the most fun when one participates.

About Dr. Gervase J. P. Barger. He graduated from the George Washington University Medical School in 1914. In 1924–25 he studied physical education at the University of Wisconsin, and he became a Diplomate in Physical Medicine in 1947. Dr. Barger taught physical medicine at Georgetown University Medical School and Hospital for nine years ending in 1946.

J. Earl Kadan, M.D.

Annual Meeting of AMA

(*Continued from page 464*)

of Chest Physicians, June 20, Dr. Sol Katz read a paper on "The Use of Salizid in the Management of Tuberculosis."

The Georgetown University Medical Alumni Luncheon was held at the St. Francis Hotel, and the George Washington University Medical Alumni Luncheon at the Fairmont Hotel, both on June 22.

The midyear Clinical Session of the AMA will be held in Miami, Florida, November 30–December 3; the 104th Annual Meeting of the Association will convene in Atlantic City, June 6–10, 1955.

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THE RELATION OF CIRCUMFERENTIAL LYMPHATIC SPREAD OF BLADDER CANCER TO INDICATIONS FOR SPECIFIC SURGICAL TREATMENT*

ROGER BAKER, M.D.
Professor and Director of the Department of Urology, Georgetown University School of Medicine

PROBABLY the most significant recent contribution to the problem of bladder cancer was made in 1946 by Jewett and Strong.[1] They established present therapeutic and prognostic criteria by a correlation of clinical with pathologic findings. This study has been confirmed and extended by Marshall,[2] Colby and Kerr,[3, 4, 5] and others. Observations from this laboratory have been identical, namely, that there is a definite relationship between depth of tumor invasion of the bladder wall to therapy and prognosis. One of the outstanding conclusions of these clinical investigations is that cancer of the bladder that has deeply invaded the muscularis is usually fatal to the patient if treated by transurethral or segmental resection, radiation therapy, or simple cystectomy (no lymphadenectomy). These reports and subsequent papers have indicated that potentially 60 to 84 per cent of cancers that have penetrated approximately less than midway through the muscularis are curable if treated by any of the accepted methods: transurethral resection, segmental resection, radiation therapy, or cystectomy.

To extend Jewett's important study in a different area, it would be of interest to determine if there is a correlation between depth of growth and circumferential spread of cancer cells within the vesical lymphatics. In addition, data are still lacking concerning the incidence, if any, of patients with bladder cancer that has penetrated through less than 50 per cent of the muscle that has tumor cells in regional lymph nodes.

Baker, Govan and Sawyer[6] described the distribution of vesical lymphatics in the dog. It was demonstrated that the lymphatics interlace and cross the midline of the bladder anteriorly and posteriorly. One tenth of 1 cm. of a large particle colloidal suspension injected at any site beneath the mucosa disseminated particles in lymphatics throughout 25 to 50 per cent of the bladder circumference within 24 hours. No particles were observed in the mucosal layer. The most distant spread within the bladder was noted constantly in the muscle layers rather than adventitia. Even this small quantity of colloidal particles injected in the submucosa produced involvement in the regional lymph nodes in 60 per cent of dogs examined. The report now presented of the circumferential spread of cancer within the wall of the bladder and determination of the incidence of involvement of regional lymph nodes from bladder cancer is an outgrowth of this preparatory research.

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* Read before the Mid-Atlantic Section of the American Urological Association in Washington, D. C., April 24, 1954.

Procedure

A total of 18 bladder specimens were studied from patients with cancer that had varying degrees of infiltration and cellular characteristics. Ten total bladder specimens were obtained by surgery or at autopsy and had cancer penetrating through 50 per cent or more of the muscularis. Five cystectomy specimens were from patients with bladder cancer that had penetrated varying degrees of the muscle. Three of these latter bladders were excised 1 to 2 weeks after the tumor had been resected as completely as the transurethral approach permits. The remaining 3 specimens were each of at least one-half the bladder (hemicystectomy) and had been removed because of a malignant lesion that had not infiltrated more than halfway through the muscle.

The total bladders were inflated with formalin, and all specimens were immersed in the same solution. Celloidin embedding and hematoxylin and eosin stain were used. Coronal sections were taken through the entire bladder at the level of the tumor.

Lymphadenectomy was performed by the same method in each patient. This consisted in complete stripping of all tissues from the external, internal, and common iliac arteries and veins as well as the terminal aorta and inferior vena cava. In each patient 21 to 60 lymph nodes were excised and studied. After completion of this systematic vascular stripping, all vessels were free of surrounding tissue and could be easily manipulated.

Results

TUMORS APPROXIMATELY 50 PER CENT OR LESS THROUGH THE MUSCLE

Mucosa. No cancer specimens in this series involved only mucosa.

Mucosa and submucosa. Two specimens were examined. In neither instance had the tumor invaded any vesical lymphatics.

Mucosa, submucosa and superficial muscle layers. Three specimens of this type were studied and 2 had local lymphatic spread within the bladder wall. One of these tumors was sessile and the other was a broad-based papillary lesion. Tumor cells plugged lymphatics only within the muscularis. Circumferential spread away from the periphery of the lesions was about twice the diameter of the base of the lesions (mucosal size). One tumor base was about 2 cm. in diameter, and tumor cells were observed in the muscularis on either side of the growth totaling approximately 4.5 cm. in diameter (figures 1 and 2). No tumor bearing regional lymph nodes were found in this series.

Mucosa, submucosa and less than about 50 per cent of muscle layers. This group consisted of 5 specimens. It was an unexpected finding to learn that 3 tumors had not invaded vesical lymphatics to any degree appreciably greater than if only superficial muscle fibers were infiltrated. Regardless of deeper muscle invasion of the tumors in this group only 2 of the 5 specimens had marked circumferential spread of tumor cells. All spread was again within the lymphatics of the muscularis. None was observed within the adventitia. In the 2 specimens mentioned the tumor had spread 2 and 6 times the diameter of the tumor base as determined by mucosal size. One of these 5 patients also had an ipsilateral common iliac node containing malignant cells.

TUMORS APPROXIMATELY 50 PER CENT OR MORE THROUGH THE MUSCLE

Contiguous local spread did not extend for too great a distance from the gross lesion when referred to endoscopic appearance or palpation of the bladder wall. Within the mucosa, tumor cells did not extend microscopically away from the lesion for more than several millimeters other than could be observed grossly. The greatest spread of cancer cells occurred in lymphatics and between planes of the musculature. The average bladder circumference microscopically involved for this group was about 60 per cent. One specimen with cancer that had penetrated through all layers of the bladder had cancer cells in lymphatics of 90 per cent of the circumference of the bladder. Only 1 bladder failed to have more than one-third bladder involvement. This was a squamous-cell carcinoma of approximately 2 cm. in diameter that had invaded the deeper reaches of the muscularis. Lymphatics of the bladder contained cancer cells for only about 20 per cent of bladder circumference. This patient had an ipsilateral common iliac lymph node carrying cancer cells. Eight of the 10 patients studied had at least 1 regional lymph node containing cancer.

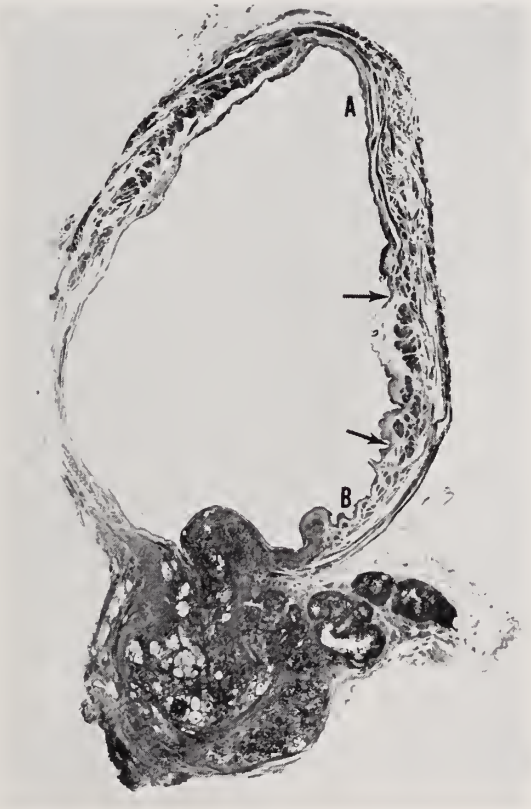

FIG. 1. A typical total section of the bladder. This section demonstrates a lesion involving the mucosa, submucosa and superficial muscle layers. The arrows indicate the extent of the malignancy that may be determined by transurethral observation or by palpation if segmental resection is performed. "A" and "B" indicate the circumferential lymphatic spread of the malignancy within the bladder wall. Transurethral resection or the routine segmental resection would obviously be inadequate therapy.

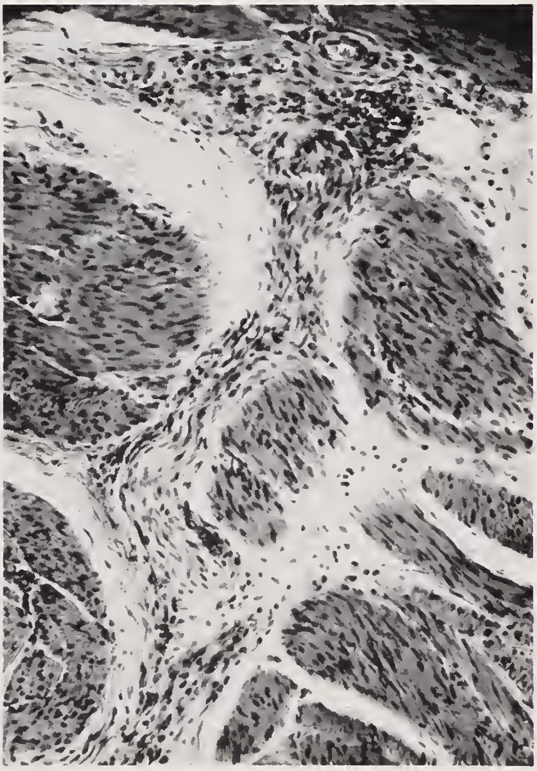

FIG. 2. Cancer cells plugging lymphatics at "A" (see figure 1).

DISCUSSION

Too little emphasis has been given in published data between mortality after cystectomy due to recurrence of cancer or due to renal disease subsequent to diversion of the ureters. It is true that death from one cause is equally as fatal as death from another. Failure to clearly state the cause, however, does little to increase our knowledge of either aspect of the problem and can unreasonably weight statistics. Although cystectomy has been included as effecting the same percentage of cure as more conservative therapeutic procedures for bladder cancer, these figures are probably unjust to the true potential of the operation and must be qualified. In the vast majority of published reports cystectomy has been used as a "last resort" type of operation when transurethral or segmental resection has failed to cure the lesion. As such, these cases must also be classified as failures of transurethral or segmental resection as well as cystectomy. Of greater concern, however, is the injudicious use of cystectomy in this type of patient. In my opinion it amounts to a surgical attempt to cure the surgically incurable.

Where cystectomy has been employed as a first procedure for infiltrative or noninfiltrative bladder cancer, most have been performed without lymphadenectomy, or at least there is no mention of the procedure in the reports. It is a rare paper that states that lymphadenectomy was performed and the procedure described. There is no common understanding of the term lymphadenectomy. Some urologists imply palpation for enlarged nodes; others explore bifurcation of vessels and excise enlarged nodes; only a few surgeons explicitly state that all regional arteries and veins were stripped clean of adjacent and surrounding tissues. Leadbetter has been a leader in advocating this latter type of complete removal of lymphatics and lymph nodes. Unfortunately, the better statistics produced by this tedious, systematic brand of surgery for infiltrative or noninfiltrative bladder cancer are weighted down by other reports in which only simple cystectomy (no lymphadenectomy) is performed.

The decision as to whether cystectomy and lymphadenectomy will be performed must necessarily rest on an integration of other factors, such as general condition of the patient, age, temperament, status of ureters and renal function, hospital house staff and facilities, and experience of the surgeon. This facet of the problem is not under discussion in the present paper. This preliminary report does attempt to correlate the approximately predictable circumferential spread of tumor cells within the bladder for tumors of known depth of infiltration.

From the viewpoint of the urologist, transurethral resection of all bladder cancers is easier, technically, than either cystectomy or segmental resection. In addition, the patient has a shorter, smoother, pain-free hospital convalescence. Unfortunately, there are several major objections to transurethral resection of malignant tumors. First, the surgeon is restricted in the extent of his resection by the possibility of perforating the bladder; second, he judges depth of tumor invasion (and hence resection) by the highly subjective norm of visual impression; third, the peripheral or circumferential extent of the lesion and resection is subjectively determined by the gross appearance of the tumor and normal bladder; fourth, no lymphadenectomy is possible with this surgical route. Clinical experience has proven definitely that transurethral surgery is curative for a certain group of vesical cancers. The problem is to accurately determine by transurethral biopsy which group of tumors comprise this group.

From the broad aspect of potential curability of bladder cancer, segmental resection is generally to be preferred over transurethral excision, because it is possible to remove the entire wall of the bladder at the site of the tumor along with adjacent normal bladder wall. With deeply infiltrative tumors about 60 per cent of the entire circumference of the bladder lymphatics may contain malignant cells. The futility of performing the routine segmental resection with the usual cuff of normal bladder is obvious. Tumors of even a less marked degree of infiltration may have locally invaded lymphatics of the muscle far beyond the "cuff of normal bladder."

Segmental resection as routinely practiced implies that the palpating fingers can feel the extent of spread of cancer cells within the bladder lymphatics around the cancer and determine the size of "normal" bladder cuff to be excised with the tumor. This concept of being able to palpate dissemination of cancer cells is nearly as untenable as the transurethral approach in which the extent of peripheral and infiltrative spread is determined visually. The classical segmental resection presupposes no regional lymphatic spread, since no lymphadenectomy is usually performed. It is readily admitted that lymphadenectomy is difficult and probably impossible to perform properly with the bladder still in the pelvis. It is agreed also that even as now practiced segmental resection does cure a large percentage of patients with noninfiltrative vesical cancer. In order to increase this percentage rate the data now presented demonstrate not that the procedure is of little value, but rather to factually indicate that a more radical segmental resection is necessary in certain patients.

As a result of the data of present study, for lesions of approximately 2 or more cm. in diameter, hemicystectomy has been used routinely. One third to two thirds of the bladder is excised with the tumor located in the center of the hemisphere. This frequently necessitates sacrificing 1 of the ureteral orifices. In these cases the ureter is reimplanted in the bladder. Six months postoperatively the remaining bladder segment distends to nearly normal capacity. I was first acquainted with the concept of hemicystectomy in 1952 by Foley.[7] Prior to bladder closure, lymphadenectomy is performed as completely as possible with the remaining segment of the bladder still in situ. Based on the coronal sections studied, if the tumor is within 2 to 4 cm. of the bladder neck, hemicystectomy is inadequate therapy. If no other serious contraindications exist, cystectomy is used for this type case.

CONCLUSIONS

It may be concluded from this study that it is not possible to state dogmatically the precise degree of circumferential vesical lymphatic spread of vesical cancer by either mucosal size or depth of infiltration of the lesion. This may be determined only by careful transurethral biopsy and is usually greater than that expected. This may well account for the present poor rate of cure in the treatment of this condition. Regardless of depth of infiltration, microscopically there is exceedingly little mucosal spread of tumor cells other than that observed endoscopically. Local and distant lymphatic spread within the bladder is usually confined to the muscularis. In the sections studied, mucosal and submucosal cancers did not spread to local vesical lymphatics. Generous transurethral resection should be adequate therapy for this group of tumors.

A small percentage of cancers invading only superficial muscle fibers may have local lymphatic involvement greater than the tumor base. No patients of this group had metastases to regional pelvic lymph nodes. Wide transurethral resection or, preferably, wide segmental resection is indicated apparently for these tumors. Lymphadenectomy is probably unnecessary.

Although tumors infiltrating approximately less than 50 per cent of the muscularis do not generally have extensive local vesical lymphatic dissemination, a few will have considerable circumferential bladder involvement, and an occasional case will have cancer in regional pelvic lymph nodes. Segmental resection or transurethral resection as routinely performed would be inadequate therapy for these patients. Hemicystectomy in conjunction with lymphadenectomy or cystectomy and lymphadenectomy should offer the greatest opportunity for totally excising cancers of this group.

It is of interest that a small percentage of tumors that have infiltrated half way or more through the muscularis failed not only to have

(Continued on page 547)

CEREBRAL HEMODYNAMIC STUDIES ON HYPERTENSIVE-ATHEROSCLEROTIC SUBJECTS DURING HEXAMETHONIUM THERAPY*

JACK KLEH, M.D.

Medical Director, Home for Aged and Infirm, Washington; Clinical Instructor in Medicine, George Washington University School of Medicine

JOSEPH F. FAZEKAS, M.D.

Chief of Staff, District of Columbia General Hospital, Washington

THE reduction of blood pressure of elderly hypertensive subjects with hexamethonium salts has been either discouraged or advised only with caution because of possible cerebral, cardiac, or renal complications. In a recent publication[1] its use was advocated in hypertensive atherosclerotic subjects. This preliminary report deals with the effect of acute and chronic reductions of pressure on cerebral hemodynamics and metabolism in 8 subjects with sustained diastolic hypertension and clinical cerebral and/or coronary atherosclerosis.

METHOD

Cerebral hemodynamic and metabolic studies were done on all subjects prior to therapy by means of Scheinberg's modification[2] of the Kety-Schmidt procedure.[3] Blood pressures were recorded twice daily for an extended period to obtain the control range.

In order to estimate the dose of hexamethonium required, the method of intravenous titration as recommended by Freis[4] was followed. Since it has been shown[5] that the cerebral metabolic rate does not change significantly with an acute reduction of pressure, the rate of cerebral blood flow was estimated from the observed cerebral arteriovenous oxygen differences and the previously obtained cerebral metabolic rate. The cerebral arteriovenous oxygen differences were determined immediately prior to the intravenous administration of hexamethonium chloride and at the time of maximum depression of mean arterial pressure. Hexamethonium was administered at the rate of 1 mg. of the ion per minute until the mean arterial pressure fell to normotensive levels. In some subjects the mean arterial pressure, nevertheless, continued to fall, and, if signs of cerebral vascular insufficiency became manifest, the patient was immediately placed in the Trendelenberg position.

In order to study the effects of gradual reduction of pressure, increasing doses of hexamethonium were administered subcutaneously twice daily until the majority of blood pressure readings fell to approximately normotensive levels with the subject in the supine position. This dosage was continued from 10 to 27 days, after which studies of cerebral hemodynamics and metabolism were repeated by means of the conventional procedure.[2]

RESULTS

Table 1 presents the cerebral hemodynamic and metabolic data obtained during the control period and during the acute and chronic phases of therapy. With an acute reduction of pressure to approximately normotensive levels, there was a significant increase in the mean cerebral arteriovenous oxygen difference and a significant decrease in the rate of cerebral blood flow. Despite the fact that on chronic administration of hexamethonium the mean arterial pressure was only slightly higher than on acute administration, the cerebral blood flow and cerebral arteriovenous oxygen differences were not significantly changed from the control values. Of the 8 subjects studied, 7 developed manifestations of cerebral vascular insufficiency during the acute titration. In none of these subjects, despite previous electrocardiographic evidence of coronary artery disease, did signs or symptoms of acute coronary insufficiency develop.

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Hexamethonium chloride (Esomid) was generously supplied by Ciba Pharmaceutical Products, Inc., Summit, New Jersey.

During chronic administration, when the dose of hexamethonium required to produce a fall of blood pressure to approximately normotensive levels was established, 4 patients continued to exhibit signs of cerebral vascular insufficiency following medication. A single episode of coronary insufficiency confirmed by electrocardiographic changes developed in one subject during chronic hexamethonium administration. In only 1 instance was any improvement noted with hexamethonium therapy, and this followed its administration during an episode of acute hypertensive encephalopathy.

The calculated cerebral vascular resistance in the acute studies decreased from 4.4 to 3.5; whereas on chronic administration there was a much greater reduction to 2.6. The greater degree of relaxation of the total cerebral vasculature with a chronic reduction of the mean arterial pressure is the most probable explanation for the maintenance of a normal rate of cerebral blood flow. Apparently, however, despite this significant reduction in vascular resistance, circulatory adjustments in certain areas must have been inadequate, since signs of cerebral vascular insufficiency continued to occur. This is most likely due to failure of relaxation of the more arteriosclerotic cerebral vessels and a proportionately greater dilatation of those less involved in response to a reduction of the mean arterial pressure.

It is interesting that despite electrocardiographic evidence of myocardial insufficiency

TABLE 1

Effects of Acute and Chronic Hypotension on Cerebral Hemodynamics and Metabolism

AGE	MAP			CBF			$CMRO_2$		CVR			AVO_2		
	C*	E_a	E_c	C*	E_a	E_c	C	E_c	C*	E_a	E_c	C*	E_a	E_c
64	180	135	94	39.1	33.1	38.1	2.4	1.6	4.6	4.1	2.5	6.16	7.24	4.25
55	153	102	93	40.6	26.1	45.8	2.2	3.2	3.8	3.9	2.0	5.75	8.43	7.05
64	173	75	84	42.5	30.6	41.5	3.3	3.6	4.1	2.5	2.0	7.82	10.77	8.62
61	148	71	105	20.3	10.6	27.8	1.2	1.9	7.3	6.7	3.8	6.77	11.28	6.80
76	150	68	110	39.2	26.8	49.6	3.0	4.0	3.8	2.5	2.2	7.70	11.18	8.05
72	163	72	98	41.2	24.1	44.3	2.6	3.3	4.0	3.0	2.2	6.72	10.77	7.52
71	171	56	90	53.4	24.9	46.4	3.1	4.8	3.2	2.2	1.9	5.82	12.46	10.33
59	153	80	112	32.4	23.6	29.2	2.2	2.3	4.7	3.4	3.8	6.89	9.32	7.78
Mean Values														
65	161	82	98	38.6	25.0†	40.3	2.5	3.1	4.4	3.5	2.6†	6.70	10.18†	7.55

MAP signifies mean arterial blood pressure in mm. of Hg; CBF, cerebral blood flow in c.c./min./100 Gm. of brain; $CMRO_2$, cerebral oxygen consumption in c.c./min./100 Gm. of brain; CVR, cerebral vascular resistance in mm. Hg/c.c. blood/min./100 Gm. of brain; AVO_2, cerebral arteriovenous oxygen difference in volumes per cent. C indicates control, E_a, experimental acute, and E_c, experimental chronic.

* Value represents the average of 2 observations.

† Significant difference, $P < .01$.

prior to therapy in the majority of our subjects, only 1 exhibited clinical coronary insufficiency. There may be several explanations for the greater susceptibility of certain cerebral cells to reductions in pressure. Both the brain and the myocardium are highly dependent upon the mean arterial pressure to maintain an adequate oxygen delivery. Although the brain and the heart comprise only approximately 2.5 per cent of the total body weight, they consume 32 per cent of the total oxygen uptake, and 18 per cent of the cardiac output is utilized to effect this delivery. The oxygen utilized by the brain has been estimated to be 2.5 times that of the heart and the cerebral blood flow 3.5 times the coronary flow. Thus, it should be apparent why certain cerebral cells may be more sensitive to the same reduction in mean arterial pressure than cells supplied by the coronary arteries. Further, despite electrocardiographic evidence, symptomatic coronary insufficiency was infrequent, whereas cerebrovascular abnormalities predominated in the patients prior to drug administration. This would indicate relatively more cerebral than coronary atherosclerosis.

SUMMARY AND CONCLUSIONS

Eight subjects with the hypertensive, cerebral atherosclerotic syndrome were treated with hexamethonium chloride. On acute reduction of pressure all patients exhibited signs of cerebral ischemia and significant reduction of the rate of cerebral blood flow. With chronic administration of this drug in doses sufficient to reduce the pressure to normotensive levels these manifestations persisted in 4 patients despite a rate for cerebral blood flow not significantly different from that prior to therapy.

These studies indicate that even a gradual reduction of pressure in such subjects with hexamethonium may be hazardous.

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EVALUATION OF A NEW INFANT FORMULA FOOD, BREMIL

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THE importance of evaluating the adequacy of proprietary food preparations under controlled situations cannot be underestimated. That this applies to infants in particular is pointed out by the recent observation of convulsive disorders following the feeding of a liquid milk preparation,[1] possibly due to a relative deficiency of vitamin B_6. Megaloblastic anemia has been observed in infants fed certain similarly prepared infant formulae.[2, 3] This hazard was removed after increased amounts of vitamin C were added to these milks.

When breast-feeding is not feasible there is no longer any doubt as to the acceptability of artificial feeding of infants.[4] A powdered formula has certain advantages over a liquid preparation, which compensate for the slightly longer time necessary for its preparation; it has a constant composition which is not affected by seasonal or temperature changes; it cannot "settle out"; it needs no preservative, and it is less likely to become a culture medium for pathogenic bacteria. The simplicity of prescribing a complete powdered formula to which nothing except water need be added and the ease with which it is reconstituted to a liquid milk reduce materially the chance of error with resultant problems in under- or overfeeding. Added to this is the distinct advantage of the facility with which an extra bottle or two may be made when emergency situations arise.

This is the report of a study which was undertaken with a group of artificially fed infants who were fed a powdered modified milk formula,* without addition of supplementary vitamins or iron. This study follows closely the pattern suggested by the Council on Foods and Nutrition of the American Medical Association in an attempt to verify that such a proprietary food made to resemble human milk supports satisfactory growth.[5] Accordingly, careful records were kept of the physical and neuromuscular development of these infants together with periodic blood counts and roentgenograms of the long bones to demonstrate evidence of anemia, vitamin deficiency, or delay in bone age. In addition, tabulation was kept of any intolerance of these infants to the formula, such as disturbed sleep, colic or other evidence of discomfort, regurgitation, vomiting or diarrhea, or any other symptoms of digestive disorders.

The formula under study is a completely modified milk in which nutritionally essential elements of cow's milk have been adjusted or altered to supply the nutritional requirements of infants deprived of human milk. It is not the purpose of this paper to present a detailed analysis of the chemical composition of this formula; such a study has been recently published by other investigators.[6] The resemblance of the formula to that of human milk will be noted in table 1. Of particular interest is the calcium-phosphorus ratio of 1.5:1.0. This ratio more nearly approaches the values for human milk than the average cow's milk formula (1.27:1.00), or the more commonly used evaporated milk formulas (1.05:1.00).[8] Recent reports have noted that the high phosphorus loads on the immature kidney and parathyroid glands of the newborn fed cow's milk formulas or standard evaporated milk formulas predisposed these infants to infantile tetany.[8, 9, 10]

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* Bremil, Powdered Infant Food, manufactured by Prescription Products Division, The Borden Company, New York 17, N. Y.

TABLE 1

Approximate Percentage Composition of Human Milk, Cow's Milk and Bremil

	HUMAN MILK*	BREMIL†	COW'S MILK*
Water	87.5	87.5	87.5
Fat	3.5	3.5	3.5
Carbohydrate	7.5	7.0	4.7
Protein	1.25	1.5	3.4
Minerals	0.2	0.5	0.75
Calcium	0.034	0.078	0.122
Phosphorus	0.015	0.052	0.09
Ca:p ratio	2.2:1	1.5:1	1.3:1
Iron	0.0001	0.00082	0.00004

* Data from "Infant Nutrition," P. C. Jeans and W. M. Marriott.[7]

† Reliquefied: 1 level tablespoon to 2 fluid ounces of water.

Gardner[8] reported 16 cases of infantile tetany, in all of which the infants were fed an evaporated milk or cow's milk formula. He believes the relatively low calcium-phosphorus ratio due to increased total phosphorus concentration of these formulas in the presence of decreased parathyroid-renal function is "unphysiologic." It is suggested that a smaller amount of phsophorus is assimilated when the calcium-phosphorus ratio approaches that of human milk.

Due to storage of iron in the fetal liver during the last month of pregnancy and the destruction of excess hemoglobin at birth with additional available iron, normal newborn infants whose mothers received adequate iron during their pregnancy have enough endogenous iron to meet fully the infant's requirement for iron during the first 9 to 12 weeks of life.[7] However, the fetal stores of iron at birth in a full-term infant may be considerably influenced by an iron-deficient diet of the mother during her pregnancy. Such an infant born of an iron-deficient mother has a normal blood count at birth, but anemia frequently appears before the sixth month of life. This hypochromic microcytic anemia is correctable by the oral administration of iron to the infant's diet.[11] After the first 3 to 4 months of life the iron reserve in the liver may become depleted, and, if the diet is not supplemented, a true nutritional anemia develops about the sixth month of life. Any infection or illness during this period further exhausts the stores of the infant. Jeans and Marriott[7] recommend 6 to 7 mg. of iron daily for an average infant at 6 months of age. Both human milk and cow's milk formulas are deficient in this important element. The formula evaluated in this study is so constructed as to contain 8 mg. of elemental iron in each reliquefied quart.

The advantage of "built-in" vitamins is not to be underestimated. This is one means by which there can be assurance that the daily intake of essential vitamins is adequate. Since neither human milk nor cow's milk formulas provide the needed amount of vitamin D, supplementary intake of this vitamin is necessary.[12] The chief sources of vitamin D in use today are the various preparations of fish liver oils which are customarily added to the diet by the age of 3 weeks. Cod liver oil is well tolerated at this age, although the oily nature of some of these preparations adds a possible danger of aspiration. The added vitamin D in the powdered formula under study obviates this difficulty. Ascorbic acid is essential for the artificially fed infant within the early weeks of life. Orange juice is frequently used as the source of this vitamin, but at this age the incidence of intolerance is high.[13] The thiamine content of human milk depends on the diet of the mother and may show wide variance, at times being less than the requirement of the infant. Diluted cow's milk formulas contain somewhat more thiamine, but both average human milk and average diluted cow's milk formulas contain only the minimal requirement of this vitamin.[12]

The subject formula contains all the vitamins found to be necessary for normal growth and development and adheres generously to recommended daily allowances of the Food and Nutrition Board of the National Research Council.[14] These recommended daily allowances are compared with the amounts found in this formula in table 2. The greater content of vitamin A and ascorbic acid follows the recommendations of Stevenson, who feels that the recommended daily allowances of these two vitamins may be inadequate to support optimal growth. He reports that the daily intake of a 6-month-old breast-fed infant is approximately 3,250 I. U. of vitamin A and approximately 55 mg. of ascorbic acid.[4]

TABLE 2

	MDR*	124 GM. BREMIL†
Vitamin A	1500 USP u	3200 USP u
Vitamin D	400 USP u	800 USP u
Thiamine	0.4 mg.	0.4 mg.
Riboflavin	0.6 mg.	1.0 mg.
Niacin	4.0 mg.	6.0 mg.
Ascorbic acid	30.0 mg.	50.0 mg.

* Food and Nutrition Board of National Research Council.[14]

† Each 124 Gm. of Bremil equals 15 to 16 tablespoons of Bremil powder. Reconstituted at a 1:2 dilution this would provide 1 quart of formula.

PLAN OF STUDY

Fifty-three infants were observed in the Georgetown University Medical Center Outpatient Department for a varying period of time ranging up to 9 months, at which age the study was terminated. All infants were full-term, had uncomplicated births and neonatal periods, and were considered normal, healthy infants. There were 27 females and 26 males included in this observation. Of the females, 10 were white and 17 were colored, while 5 of the males were white and 21 were colored. These infants were all born at the Georgetown University Hospital and were placed on a standard formula of 1 level tablespoon of the powdered formula to 2 ounces of boiled water before leaving the hospital. In the majority of cases this was within 5 days of birth. There was no selection of cases; any mother who did not desire to breast-feed was asked if she wished her baby to participate in the study. Most of the infants came from families of the lower socioeconomic groups and were eligible to attend the Well Baby Clinics.

These infants were examined each month during the study and received care identical to that of infants attending the other Well Baby Clinics. They were observed over a total of 351 infant months with an average period of observation of 6.6 months. The birth weights are summarized in table 3. A 1:2 dilution of the formula was the sole food given during the first 6 to 8 weeks of life, at the end of which time cereal, fruits, and vegetables were gradually added. These foods were found to be quite acceptable at that age. Meat was not added to the diet until the fifth month, and egg yolk was added at 6 to 7 months. No additional vitamins or iron supplement were given during the entire 9 months of observation.

TABLE 3

Number of Infants		53
Males		26
White	5	
Colored	21	
Females		27
White	10	
Colored	17	
Birth Weights		
Males	5 lbs. 12 oz.-8 lbs. 11 oz., avg. 7 lbs. 3 oz.	
Females	5 lbs. 13 oz.-8 lbs. 10 oz., avg. 7 lbs. 3 oz.	
Total Infant Months—351		
Average Period of Observation—6.6 months		

RESULTS

As standards for demonstration of adequate physical growth of this group of infants, the physical measurement charts of the Department of Pediatrics, State University of Iowa, as developed by Jackson and Kelly[15] were selected. These charts have certain disadvantages for the purposes of this study, since they were constructed from data of superior American white children from the higher socioeconomic groups, whereas the majority of the infants in this evaluation are colored children in a lower economic group. However, it was thought advisable to compare with superior children, especially since these charts have the advantage of simplicity and easy readability. The mean values for heights and weights of infants given the study formula are summarized in table 4 and plotted on the Iowa growth charts in charts 1 and 2. It will be noted immediately that the mean values for weight of the infants under study approximate closely those of the Iowa standards. The slight lag of linear growth in these infants is probably a reflection of the preponderance of colored infants in this series, especially colored males, who comprise 80 per cent of the male infants in the group. The muscular development of the majority of the infants was excellent. The incidence of obesity in this series was found to be 7.5 per cent (4 cases) and 1 of these infants was a Chinese infant whose parents persisted in feeding large quantities of rice after the age of 3 months. The physical appearance of these infants was reflected in their neuromuscular development as compared with the standards of Watson and

TABLE 4

MALES				FEMALES			
Age	No. of Cases	Avg. Weight	Avg. Inches	Age	No. of Cases	Avg. Weight	Avg. Inches
Birth	26	7 lbs. 3 oz.	19.9	Birth	27	7 lbs. 3 oz.	19.9
1 mo.	26	9 lbs. 9 oz.	20.9	1 mo.	27	8 lbs. 13 oz.	20.8
2 mos.	26	12 lbs. 3 oz.	22.4	2 mos.	27	11 lbs.	22.2
3 mos.	26	14 lbs. 5 oz.	23.5	3 mos.	27	12 lbs. 13 oz.	23.5
4 mos.	20	15 lbs. 11 oz.	24.7	4 mos.	20	14 lbs. 4 oz.	24.6
5 mos.	20	17 lbs. 9 oz.	25.7	5 mos.	20	15 lbs. 6 oz.	25.6
6 mos.	20	18 lbs. 7 oz.	26.5	6 mos.	20	16 lbs. 10 oz.	26.2
7 mos.	16	19 lbs. 5 oz.	27.3	7 mos.	16	17 lbs. 13½ oz.	26.9
8 mos.	11	20 lbs. 5 oz.	28.1	8 mos.	10	18 lbs. 14 oz.	27.5
9 mos.	11	20 lbs. 12 oz.	28.6	9 mos.	10	19 lbs. 6 oz.	27.7

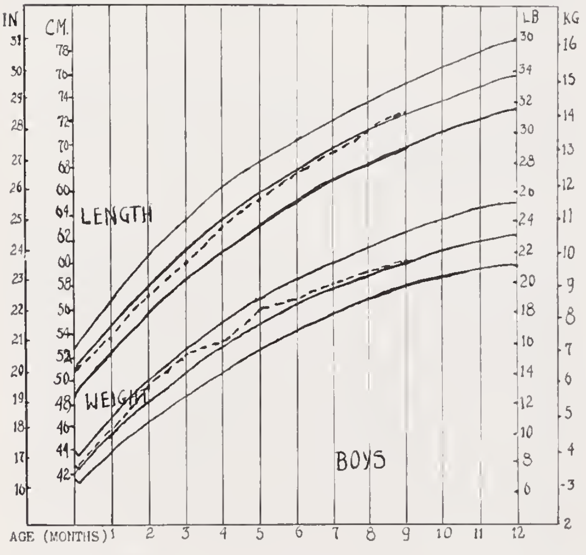

CHART 1. Mean values for height and weight of the formula infants (boys) from birth to the age of 9 months as plotted on the Iowa growth charts.

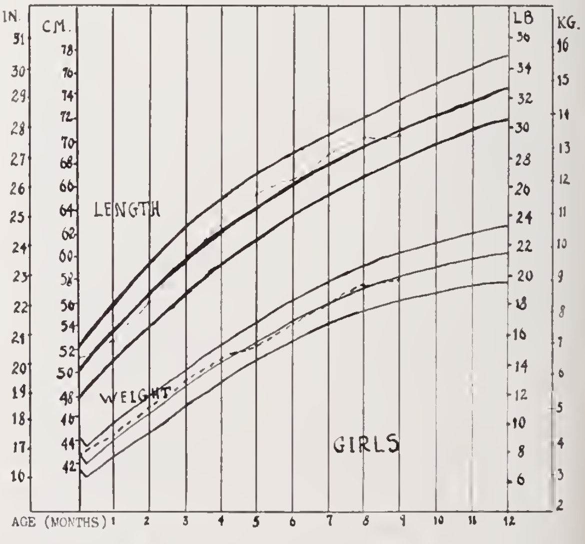

CHART 2. Mean values for height and weight of the formula infants (girls) from birth to the age of 9 months as plotted on the Iowa growth charts.

Lowrey.[16] In no instance did an infant fail to meet the standards of average development.

Roentgenograms of the long bones and ossification centers were taken of 30 infants at 3 to 4 months of age and 26 infants at 6 to 7 months of age. In only 1 case was there any evidence of "slow" bone age (table 5). This infant had had a severe parenteral diarrhea, requiring hospitalization for 10 days at the age of 2 months. Following this episode the infant's growth and development appeared to be completely normal, although a slight delay in bone age was still present at the age of 6 months. That the vitamin content of the formula is adequate to meet the recommended standards of infant nutrition is strongly suggested by the complete absence of any vitamin deficiency picture in any of these infants in whom roentgenograms were taken. This is in contrast to the study of Rhoads et al,[17] who noted a total incidence of rickets in 13.7 per cent of 233 infants receiving an irradiated evaporated milk formula or an evaporated milk formula with added vitamin D. Other investigators have noted an incidence of 15 to 38 per cent of vitamin D deficiency in similarly fed infants. In only 3 cases did Rhoads find new rickets ("mild healed rickets") after the age of 7 months. It would seem that the chance of later development of this disease in the infants included in this study would be small.

TABLE 5

Roentgenographic Picture (Carpal Bones and Long Bones)

	3–4 MOS. (30 BABIES)	6–7 MOS. (26 BABIES)
Vitamin deficiency, rickets, scurvy	None	None
Advanced bone age	4	1
Normal bone age	25	24
Slow bone age	1	1 (as before)

Hemoglobin determinations and red blood cell counts were obtained by heel puncture from these infants at the ages of 3 to 4 months and again at 6 to 7 months. Hemoglobin determinations were performed by the Haden-Hauser method. The results are summarized in table 6. These values compare very favorably with those of Usher, MacDermot, et al.[18]

The formula was liked and well tolerated by all infants included in this study. Those infants who initially attended the clinic and failed to return after one or more visits were contacted by a medical social worker. In each instance the reason given was the inconvenience of traveling the long distance from their homes to the Medical Center. These infants were referred to Well Baby Clinics nearer their homes. In no case was it found necessary to discontinue the use of the formula due to the infant's refusal to accept it or due to poor tolerance as manifested by gastrointestinal upset.

TABLE 6

Values for Hemoglobin and Red Blood Cells in Formula Babies

	3–4 MOS.		6–7 MOS.	
Hemoglobin—Gm.*				
9–10	None		1 (3.7%)	
10–11	7 (20%)		6 (22.2%)	
11–12	16 (46%)		7 (26%)	
12–13	10 (28%)	34%	10 (37%)	48.1%
13 and over	2 (6%)		3 (11.1%)	
Average	11.5 Gm.		11.4 Gm.	
RBC—Million				
2.0–3.0	None		None	
3.0–4.0	10 (28%)		6 (22.2%)	
4.0–5.0	23 (66%)	72%	19 (70.4%)	77.8%
5.0 and over	2 (6%)		2 (7.4%)	

* 100% Hemoglobin = 15.5–16.0 Gm.

At the age of 4 to 6 weeks the 53 infants in this study were taking an average of 26 ounces of formula a day with a range of 18 to 32 ounces. The formula appeared to satisfy these infants in the majority of cases, and they slept well between feedings. In two cases (3.8 per cent) the infants were described as frequently hungry, fretful or "colicky." One of these infants was taking 24 ounces of formula daily and the other, 32 ounces. Both were very well nourished and otherwise developed normally. Most of the infants under study were found to be "sleeping through" at night by the age of 4 to 6 weeks.

Two of the infants (3.8 per cent) were described to have poor sleep habits. In the case of 1 infant this wakefulness subsided spontaneously at 3 months; in the other infant it persisted until the sixth month of life.

The incidence of gastrointestinal disturbance in these infants was low. There were 5 instances of regurgitation (9.4 per cent) in this series. Regurgitation as defined here refers to "spitting up" of more than 1 ounce of formula at more than 1 feeding a day as differentiated from the small amount of formula regurgitated by some infants when being "burped." Two of these infants were obviously being overfed, and the regurgitation diminished after proper instruction to the mothers. In the remaining 3 instances, 2 infants regurgitated until the age of 3 months and 1 until the age of 6 months, but growth and development continued at normal levels and it was not necessary to discontinue the formula.

There were 10 instances of diarrhea in this series, all of which were accompanied by an obvious upper respiratory infection and all of which subsided with successful therapy of the parenteral infection. There was no instance of loose stools attributable to the formula in these infants. The average formula infant studied had 2 to 5 pasty, grayish-yellow stools daily, and the bowel movements tended to be well formed. There were 12 instances (23 per cent) of constipation during the second to fourth week, readily relieved by the addition of small amounts of prune juice to the daily diet or by the use of an occasional suppository. After the first month of life, stools were softer and less well-formed. No case of excoriated buttocks was observed in any of these infants.

No instance of "milk allergy" to the formula was observed in this series. There were only 2 instances of more than minimal eczema, both occurring in the second month of life after solid food had been added and both responding to simple measures. In the case of 1 infant the eczema cleared when the type of cereal was changed from wheat to rice; in the other there were multiple allergies to various solid foods.

Conclusions

Fifty-three newborn infants were placed on a new infant formula food without addition of supplementary vitamins or minerals in an attempt to verify the nutritional adequacy of the formula in supporting satisfactory growth and development. The period of observation ranged up to 9 months with an average of 6.6 months. This formula food is designed to closely resemble human milk, having adjusted amino acid, fatty acid and mineral patterns and containing added vitamins and iron in amounts adequate to completely satisfy the nutritional needs of the infant during the first months of life.

Infants fed the formula were found to show completely normal growth and development throughout the early months of life. There was no physical or roentgenographic evidence of nutritional deficiency.

The formula was well tolerated by all infants, and in no instance was it found necessary to discontinue the formula.

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(Continued on page 548)

THE USE OF COMBINED ESTROGEN-ANDROGEN TABLETS FOR INHIBITION OF LACTATION

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IT IS variously estimated that 50 to 75 per cent of babies delivered today are not breast-fed. Artificial formulas have been so improved during the past few years that the obstetrician today is not so insistent upon the mother's nursing. Suppression of lactation, therefore, has become a frequent problem, and there has been a tremendous number of articles written and likewise a tremendous number of medications marketed for the suppression of lactation.

The object of this work was to find a method of treatment which would be (1) effective in suppressing lactation, (2) free from side- and after-effects, (3) convenient to administer, and (4) reasonable in cost to the patient.

Smith and Smith[1] were among the first to describe the use of estrogens for the inhibition of lactation. Dodds et al[2] in 1938 first used synthetic Diethylstilbestrol for this purpose.

The hypothesis of using estrogens for inhibiting lactation has still not been proved. The sudden lowering of the blood estrogen titer following delivery releases the inhibitory effect of estrogen on the pituitary gland. Lactogenic hormone is then released and lactation results. Therefore, administration of estrogen postpartum will again suppress pituitary activity and thereby inhibit lactation.[3] Gradually decreasing doses have been recommended; otherwise this type of therapy may only postpone lactation rather than suppress it. Of greater concern, however, is the occurrence of severe withdrawal bleeding in about 6 per cent of patients treated with estrogens. Approximately 12 per cent of estrogen-treated patients have various degrees of withdrawal bleeding.[4]

To avoid this dangerous side-reaction, other workers[5, 6] have used androgens to suppress lactation. The mechanism is the same (the suppression of pituitary output of lactogenic hormone); however, there is no endometrial proliferation with subsequent withdrawal. These writers reported no after-effects or complications.

Androgens alone, however, present other problems. It is my opinion that androgens do not inhibit lactation as well as estrogens despite their wider margin of safety. Androgens are very expensive to the patient. Large oral doses are necessary because of the destructive action of the gastrointestinal tract. Sublingual testosterone allows smaller doses, but patients complain of the time consumed while the tablet is dissolving and the frequently unpleasant aftertaste. Parenteral injections are expensive, uncomfortable to the patient, and inconvenient to prepare by already-busy nurses.

Premarin with Methyl Testosterone* has been recently introduced for suppression of lactation. The rationale of this combination is that the natural conjugated estrogens (1.25 mg.) in each tablet acts as a lactation-inhibitor, and the methyl testosterone (10 mg.), while also acting as a pituitary suppressing agent, tends to counteract the endometrium-stimulating effects of the estrogen.

METHODS AND MATERIAL

Four tablets of Premarin with Methyl Testosterone were given daily for 5 days. This gave a daily dose of 5 mg. of estrogen and 40 mg. of methyl testosterone. In no case was the medication gradually tapered off, because I wished to see if sudden withdrawal resulted in uterine bleeding or in secondary breast engorgement. Since our obstetrical patients usually are kept in the hospital for 5 days postpartum, the medication was stopped at the end of that time with the hope that there would be no need for further medication at home. The manufacturer recommends 7 days of treatment in gradually decreasing doses, but this would necessitate the prescribing of a small number of tablets after discharge from the hospital with further cost and inconvenience to the patient.

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* Supplied through the courtesy of Ayerst, McKenna, and Harrison, Ltd.

Thirty patients were treated in this series. This, admittedly, is a small number, but all were drawn from my own practice, and it is the rule to encourage all mothers to nurse. Those patients who refused to nurse or who had medical contraindications make up this series. All patients were started on this medication immediately after delivery except 7 who had nursed for from 7 days to 4 months.

Results were classified as follows: Those patients who noted little or no breast engorgement were rated excellent; those who had moderate engorgement for 1 day and showed only slight milk leakage were rated good; and those who had the typical hard, congested breasts with heavy milk leakage were classed as poor.

Pain results were tabulated good or poor depending on whether the patient required any medication for relief.

Bleeding was evaluated by determining whether there was any increase in vaginal bleeding after discontinuation of medication; if so, noting on what days following medication that bleeding increased. It was thought that if there were to be any withdrawal bleeding it would occur between the seventh and fourteenth day postpartum (2 to 9 days after cessation of therapy).

RESULTS

The results were most encouraging. Of the 23 patients who were treated for the 5 days postpartum, 18 (78 per cent) had excellent results with suppression and absence of engorgement, and 5 (22 per cent) had good results. There were no failures.

None of the 23 had breast pain severe enough to require relief with codeine and aspirin medication.

Evaluating bleeding was somewhat more difficult, because it has been my experience that many patients have a slight increase in bleeding after returning home, probably because of increased activity. However, all cases of increased bleeding were electively attributed to the medication in this series. Of the 23 patients, 3 had an increase in bleeding during that period in which withdrawal bleeding would have appeared. Two patients who had stopped bleeding while in the hospital noticed spotting for 2 to 3 days 7 days after returning home, and 1 patient passed 2 small clots with no further bleeding 1 week after cessation of therapy.

Four patients (13.3 per cent) noted moderate congestion of the breasts for a day or two within a week after stopping the use of the tablets. These same patients also had leakage of milk after this secondary breast congestion, lasting up to 2 weeks.

Seven patients who had nursed for from 7 days to 4 months were also given Premarin with Methyl Testosterone for suppression of lactation. All of these patients were lactating adequately for nursing their infants. Three patients were treated within 2 weeks postpartum because of medical contraindication. Since this type of treatment for lactating mothers is generally unsatisfactory, it was somewhat surprising to note that all patients showed no engorgement at all with medication, although there was much more milk leakage than in the nonlactating mothers. There were no cases of withdrawal bleeding in these 7 patients.

Of interest were the comments of the mothers undergoing this therapy. All of the multiparous women who had received testosterone propionate by injection following their previous deliveries expressed their preference for the oral tablet because of the better results in milk suppression and their antipathy toward "shots."

SUMMARY

Thirty mothers, 23 in the immediate puerperium and 7 previously nursing, were treated with Premarin with Methyl Testosterone for suppression of lactation. All had good or excellent results, although those patients who had been nursing noted considerable leakage of milk.

There was minimal breast discomfort in all 30 patients, none of whom required medication for the relief of pain.

Four patients had mild secondary engorgement of the breasts within a week after stopping medication.

Three patients noticed increase in vaginal bleeding after discontinuation of the drug. Bleeding was minimal with vaginal spotting in 2 cases and passage of 2 small clots in 1 case.

CONCLUSIONS

Premarin with Methyl Testosterone is an effective inhibitor of lactation with minimal side- and after-effects. The entire course of treatment may be given in the hospital postpartum. This drug seems to have small capacity to induce withdrawal bleeding, the most dangerous side-effect of the usual lactation-inhibiting drugs.

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THE NEUROSES FOLLOWING TRAUMA*

Part I

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THE designation "traumatic neurosis" has had rather wide application in medicine and psychiatry since its original use by Oppenheim nearly one hundred years ago. There are a number of reasons, however, why the present discussion is not so titled. First, opinion continues to vary as to the proper boundaries of any such possible specific entity. This is reflected in the failure to date to accord it an established position in the AMA and APA diagnostic and statistical classification. Second, the literature continues to reflect a rather wide diversity of opinion as to the emotional responses which various authorities so name. Various authorities use different labels for their discussion of similar neurotic reactions. Finally, it is a fact that the clinical variety of neurotic illness which is seen having its onset following trauma covers a very broad spectrum.

In the broadest sense all emotional disturbances are traumatic in origin. Trauma is either psychologic or physical or both. Specific traumatic incidents largely of a psychologic nature are uncovered in the definitive psychotherapy of every neurosis. These have contributed in varying degree to its development. On occasion they have served to precipitate an incipient neurosis or to aggravate an unstable emotional situation previously latent.

In the ensuing discussion we shall, of course, not follow this very broad definition. Our margins, however, will be kept broad enough to include all those neurotic situations in which major significance is attached by the patient, the physician, or both to preceding trauma. Neuroses following trauma will therefore be considered to include these kinds of neurotic reactions without regard to their clinical manifestations, type, or combination. The major factor in common will be that the clinical onset follows trauma. It might be further noted that the degree of any actual physical trauma can vary from major to minor and, indeed, for all practical purposes, even to the nonexistent. Likewise, the time of onset of symptoms following the trauma can vary from immediate to a separation by a considerable period of time.

Many terms have been introduced for the diagnosis and classification of the emotional reactions incident to trauma. These include traumatic neurosis; occupational neurosis; stress reaction; industrial, accident, or compensation neurosis; and concussion or blast "syndrome," as well as the various names given to the emotional reactions incident to combat and military operations (which will be listed later). Authorities favor different ones of these. Several have distinct disadvantages. In view of the many categories which fall within the scope of our discussion, as well as the wide variety of clinical manifestations seen, we cannot be exhaustive. I will, however, attempt to cover the important principles which are involved in the theory, clinical manifestations, dynamics, and treatment of the emotional reactions following trauma.

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This is Part I of the final article in a series by Dr. Laughlin covering the psychoneuroses, which began in the August, 1953 issue of the MEDICAL ANNALS. Part II will appear in the October issue.

This entire series will be revised and included with selected additional material in a forthcoming psychiatric text by Dr. Laughlin, entitled "Evaluating the Neuroses," and scheduled for publication early in 1955 by W. B. Saunders Co., Philadelphia, Pa.

Let us pause to consider briefly how neurotic symptoms are formed. In perhaps oversimplified fashion the anxiety accompanying intolerable ideas or impulses helps bring about their repression. We have seen this illustrated repeatedly in many clinical examples already presented. It is these repressed impulses in turn which give rise to various symptoms. The symptoms of neuroses are part of the defensively intended but psychologically uneconomic neurotic efforts at adjustment. Their symbolic significance varies greatly and has a clearly individual specificity. Many symptoms subserve directly or symbolically several simultaneous purposes. These include:

1. A kind of psychologic flight
2. A form of attempted ego defense
3. A simultaneous (but concealed and often symbolic) gratification and protection against performance of the denied impulse; and, not infrequently
4. A satisfaction of unconscious needs for punishment.

Saul[1] has stated that "the functional neuroses and psychoses are ways of reacting." I might carry this a step further and say that these emotionally pathologic patterns are actually "ways of life." For the individual concerned they represent his own best efforts at living and adjusting to life as it exists for him. The following tabulation of some of the intended purposes and the psychologic "anatomy" of the psychogenic symptoms of emotional illness may help in clarification.

Emotional Symptoms

Below is an outline of the major intended purposes of symptoms in emotional illness (the endogain) and their psychologic structure.

A. Symptoms attempt to serve as one or more of the following:

1. A form of psychologic *flight* and/or *fight*.
2. One or a combination of the common ego defenses or mental mechanisms.
3. Secret (symbolic) gratification of the disowned wish.
4. Prevention of overt activity toward such gratification.
5. Denial of the wish or drive.
6. Satisfaction of needs for punishment.
7. Avoidance of conscious awareness of the conflictual ideas or impulses, and the resultant anxiety.

B. The psychologic structure or "anatomy" of most symptoms include one or more of the following:

1. Prior repression of intolerable ideas or impulses as the result of consequent anxiety. These are usually basically hostile-aggressive or sexual. In the symptom they are often symbolically expressed and defended against at the same time.
2. Symbolism, by which the outward expression of the forbidden impulses is concealed, disguised, and devious.
3. Distortion further hides and lessens any chances of recognition by the more usual means of observation.
4. Condensation, by which one symptom can represent from one to many things in greatly complex and condensed fashion.
5. Displacement, as in the phobias, may aid symbolism and distortion.
6. Elaboration and extension of original symptoms may occur to include adjacent or related areas.
7. In the analysis of symptoms, the convergence of associations is helpful, as with dream interpretation. This principle is occasionally more apparently operative when there are multiple symptoms.
8. Regression.

Some of the factors as outlined can be rather readily seen to enter into the neurosis following trauma, whereas others may remain quite obscure. This will be seen further in clinical illustrations. Since the traumatic situation involves stress, tension and anxiety, we can expect to find many physiologic disturbances and somatization reactions. These may be properly referred to as "physiologic conversions" in similar fashion to the use of "hysterical conversion" to refer to the physical symptoms of hysteria. This is particularly true in the acute reactions, such as combat exhaustion and certain acute civilian stress situations.

Theory and Principles

Oppenheim in his original use of the term "traumatic neurosis" formulated a theory of molecular changes in the nervous system which he believed took place as a consequence of the trauma. Although this was soon discarded, the idea of physical change of some kind continued for a time and has been reflected in such terms as "shell shock," "concussion syndrome," and "blast reaction." Substantial evidence has not been gathered to scientifically support the various theories which have been evolved proposing an organic basis for the various kinds of nervous symptoms seen following trauma. As a result, terms reflecting theoretical organic changes have largely fallen into the discard. As an example, shell shock has been replaced in military usage by such terms as "combat and operational fatigue," "combat exhaustion," "stress reaction," "war neurosis," and, in suitable cases, "psychophysiologic or somatization reaction." In contrast, a large body of data has been accumulated clearly establishing the basic psychologic origins of the symptoms commonly seen in connection with these reactions.

We owe much to the pioneering work in understanding the close relationship of emotions and physiologic changes to Beaumont and his startling observations of the exposed gastric mucosa of Alexis St. Martin. Beaumont described the changing function of gastric secretion and digestion in response to various environmental changes and stimuli. His observations revolutionized existing early concepts of physiology. For some of our understanding of the effects of repeated stimuli we are indebted to Pavlov for his epochal work in describing the development and operation of the "conditioned reflex." It is not difficult to carry over some of our knowledge here into the effect of chronic stress or repeated trauma upon the human economy and its physiology.

It remained for W. B. Cannon[2] to conduct further definitive studies on the physiology of the emotions. Through his carefully conducted experiments he studied the bodily changes occurring in fear, hunger, pain and rage. Cannon's work is classic. Through it he evolved the concept of the individual's physiologic "emergency mobilization for fight or flight."

Any threat must be measured in terms of its individual meaning to the person concerned. In other words, its effect on the personal psychologic economy will depend upon the amount of threat which is experienced subjectively and not upon any objective evaluation. The degree of emergency mobilization will vary accordingly. If the threat experienced is great, the "E. M." will be maximal. Occasionally the threat is simply overwhelming when physical dissolution is imminent. Instances have been reported where E.M. does not take place. I refer here to the rare instances in which a person has fallen from a cliff or elsewhere toward certain death, only to have his life miraculously spared and to later report feelings of tranquillity or even a strange exhilaration. In these and perhaps similar instances of apparent certain demise, the psyche retreats to what may be a deeper, more primitive level of denial and passive acquiescence in the implicit acceptance of the futility of standing against the inevitable. Another defense on a deep level which has both physiologic and psychologic implications is post-traumatic amnesia, which has been referred to earlier.[3]

Cannon's work helped to call attention to the individual's automatic measures in preparation to meet danger. This emergency mobilization is an important part of what I have found convenient to call the "E.P.R.C."—the emotional-physiologic response to crisis. In making an estimation of or interpretation of a person's E.P.R.C. its high degree of individual specificity must be borne in mind. It shows the effects of reflex activity, conditioning, conscious control, and past experience. The individual's E.P.R.C. is the sum total of his responses in a threatening situation. It plays a vital protective role in overall defense, which also of course includes offense. The emotional-physiologic response to crisis includes the creation of potential for action. The name itself conveys the close interrelationship of the physical, physiologic and psychologic, all of which are included.* The E.P.R.C. and its healthy and efficient functioning is a vital part, and often an accurate accessory indicator of one's relative emotional adjustment. The reader is invited to pause at this juncture for a brief assessment of his own E.P.R.C. Is it appropriate? How effective and useful to him is it? Is the net result constructive or destructive? How does it affect his relationships, his daily living, his meeting threats and danger? Does its operation contribute or interfere with his satisfactions in living?

Let me raise the question here as to why, if a number of people were exposed to approximately the same traumatic experience, a few might develop emotional disturbances which in turn would be of varying degrees, and many would be unaffected. This is amply illustrated in wartime ship-sinkings,[4] bombings and civilian disasters. Then, too, experiencing misfortune is common to all. As Shakespeare said in "All's Well That Ends Well" (IV:3,83), "The web of our life is of a mingled yarn, good and ill together." Part of the answer is implied above. The important factors governing the onset in post-traumatic neurotic difficulties are by no means confined to the trauma. The preëxisting personality make-up and adjustment are vital in such determinations. Individual susceptibility and vulnerability run the gamut of possibility. Let me briefly illustrate the onset of a severe neurosis following a traumatic event which was seemingly almost nonexistent, at least from any physical standpoint.

Case 1. *The onset of a severe neurosis following minimal trauma.* A 41-year-old mechanical engineer was seen in consultation because of weakness, severe headaches, blurred vision, sleeping disturbances, nervousness, and tremors which had progressed to the point where he was unable to work. The clinical picture most nearly fitted into the older descriptive concept of neurasthenia with hypochondriacal overtones. The patient appeared tired, thin, worn-out, apathetic, and discouraged. His speech and manner showed little spontaneity or expression.

This patient dated all his symptoms to what he described as a "serious head injury which I suffered when the ceiling fell down on me." Independent observers described the breaking loose of a small (approximately 1 by 2 foot) section of plaster which flaked apart as it fell in a shower of small fragments and dust over the patient and his drafting board. It is apparent in such a situation that calling attention to the discrepancy between how the severity of the trauma is estimated by the patient and in turn by others serves little constructive purpose. The exaggeration by the patient is necessary to fit into his deeply fixed internal needs, which are emotional in origin and which will not respond to logic. This patient's symptoms began promptly and progressed rapidly to a severe plateau where they tended to become fixed for several months prior to the time I saw him. The external event from the standpoint of its objective slightness appears to merely serve as a convenient attachment for something perhaps all ready to occur.

Enough background material was gained to indicate a passive dependent adjustment in a person with an insecure early family environment whose economic and professional adjustment had long been marginal, especially in view of his training. Both in his marriage and at work his adjustment had been gradually becoming increasingly precarious. It was as though the accident represented on one level a welcomed way of retreat into a more passive position from an increasingly intolerable, more active one. From the steady progression of his level of insecurity and the threatened collapse from any one of several quarters (i.e., marriage, family, professional standing, loss of his position, etc.) the "roof" might well fall in on him at any time. Accordingly, the actual small ceiling collapse could have had considerable symbolic meaning for him as the impotent, helpless person caught in the web of his own adjustmental and emotional inadequacies and impotently awaiting some area to give way or collapse. Actually this type of neurotic collapse is seen frequently enough following similar plaster collapses to well warrant speculation as to this kind of underlying symbolism.

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* These are likewise seen in the "E.P.R.T."—the emotional-physiologic response to trauma. This is similarly the sum total quantitative individual response to psychologic or physical injury.

Let us proceed now to the other end of the scale where the actual trauma is maximal. In the case to be summarized, the trauma to which this particular man was exposed was not only terrific but was repeated on three subsequent occasions in increasing crescendo, although with various modifications. I feel also that this type of case bears out further my own conviction that every person, no matter how stable and emotionally well integrated, will reach a breaking point, given sufficient stress.

Case 2. *Neuroses following repeated maximal stress.* It was fashionable in some psychiatric circles for a time during World War II to emphasize the constitutional and psychologic "weakness or predisposition" of service men who became unable to carry on because of incapacitating emotional difficulties during or following combat. In support of his thesis along these lines late in the War, a colleague pointed out to me a passing naval petty officer. "Look at that sad-looking specimen," he said. "Do you think he ever had much stability or could have amounted to much? From when I first saw him on admission 2 days ago, it was evident that this is a prime example of the basically inferior and unstable person."

"Get them in the service," he continued, "and expose them to a gunshot or 2, and, poof! they collapse. Furthermore, he is guilty about his failure. Won't talk much and admits he saw little action and that there's no reason why he should be nervous. I couldn't get any psychologic determinants from him, but I bet a real history would find most of them. He is just typical of the weak and inferior type of person who just can't take it."

Half-listening to him, I had noticed something vaguely familiar about the chap. He seemed a washed-out and shadowy caricature of someone I had perhaps once known. I noted his specialty rating—quartermaster, and then it came to me. He had served with me aboard ship some years earlier through all kinds of strenuous operational and combat conditions. He was barely recognizable. Physically, he had shrunken and aged unbelievably since the time when I had last seen him. Then he had been a strong, young, self-possessed person imbued with that rock-like quality which invites other men to lean on them and to implicitly accept them as leaders. Now he was an aged, palsied, defeated, and pathetic figure, shriveled and shrunken to nearly half his former weight.

How poor an example my colleague had picked! Serving as shipmate with this man on a destroyer during the touch-and-go of the early months of the War had provided me with an unequaled opportunity to learn to know him under all kinds of stressful situations. His own E.P.R.C. had functioned at least as ideally as that of anyone aboardship. The exigencies of war had led our vessel to South America, through North Atlantic convoy duty, to the Caribbean, through the Casablanca (North African landings) operation, to Australia and the South Pacific, New Caledonia, the New Hebrides, participation in the final phase of Guadalcanal, and the Solomons. We had been in the first hesitant and tentative advances northward, up the famous "Slot," past "Iron Bottom Bay," Savo Island, the Russel Islands, and the New Georgia operations. Our ship was reputedly the first vessel to sail past Savo and return afloat. During every situation, no matter what impended, this man had been a tower of strength. On July 5, 1943, the first *U.S.S. Strong* was sunk during an engagement in Kula Gulf under conditions of great stress for her personnel. Among the survivors a fair number developed combat fatigue and stress reactions. Not so this man. He had promptly returned to duty on another destroyer, outwardly unfazed by his harrowing experience superimposed upon prolonged stressful operations.

Naturally interested scientifically as well as personally in what conceivable stress could account for such unbelievable changes in a man I knew to have been of such outstanding caliber, I spent some time with him and learned the history of the subsequent years. The tempo of stress had not only continued uninterrupted but had, if anything, increased. Briefly, he had continued an unusually extensive combat service on 2 subsequent destroyers, each of which was sunk in turn, he among the survivors. After the second experience he had his first nervous symptoms. These gradually increased during service aboard ship number 3.

His last traumatic experience on ship number 4 prior to hospitalization had in it all the worst elements of trapped helplessness. Scouting enemy shore battery positions believed to have been silenced on Southern Okinawa, his ship ran hard aground on a poorly charted ledge. At this point, the shore batteries opened up at point blank range, pouring salvo after salvo into the helpless ship with hundreds of rounds of ammunition. With all attempts to retrieve the situation proven futile, and the vessel riddled, those still surviving were ordered to abandon ship. My former shipmate got off the ship only to find himself slowly being drawn back by the tide, despite his strongest swimming efforts, toward a large area where the surface was covered by burning oil from the stricken destroyer. He didn't know how long this lasted but he managed to stay clear long enough so that the enemy batteries were eventually silenced and he was rescued.

Perhaps the reader may gain some idea from this brief sketch of the tremendous stress to which this man was subjected. I had seen, of course, many instances where persons lost their effectiveness in response to minor or moderate stress. At the time, this case helped bring home most forcibly to me the tremendous individual variance in tolerance to stress during combat and stressful military operations. I have no data here as to further possible reënforcement of the impact of the final traumatic event by virtue of hidden symbolism. On the face of it, however, such a contribution would hardly seem necessary.*

This illustration brings us to another important principle in the onset of neurotic symptoms following trauma. Although it is true that symptoms were present earlier, the final climax in this case took place at a time when elements of powerlessness and helplessness were about as marked as one can imagine. Thus, the presence of relative impotence or helplessness in the face of threat, danger, or feared unknown impending change, or feelings of incapacity to cope with or to influence the threatening situation, increase both the person's physical and psychologic vulnerability. This is an important concept in our study of the psychologic concomitants of trauma and the individual E.P.R.T. The relative individual impotence or helplessness can be contributed to greatly by the reënforcement of hidden symbolism.

Repeated exposure to trauma (and chronic stress) can undermine confidence in one's continued ability to cope with threats and can increase weariness, fatigue, disillusionment and cynicism. It is as though there is a "wearing down" process which enters into a possibly increased susceptibility to neurosis. From this viewpoint it is sometimes as though the psychic energy and resources become depleted and the defenses weaken or collapse.

Freud,[6] in 1926, in discussing a traumatic situation, noted in similar terms that it consisted of the subject's estimation of his own strength compared with the magnitude of the danger and his admission of helplessness in the face of it. He divided this helplessness into physical, when the danger is objective, and psychologic, when the danger is instinctual. Freud[7] had earlier offered this general definition: "An experience which we call traumatic is one which within a very short space of time subjects the mind to such a very high increase of stimulation that assimilation or elaboration of it can no longer be effected by normal means, so that lasting disturbances must result in the distribution of the available energy in the mind." I assume that Freud would include in such stimulations both physical and psychologic factors, including contributions or reënforcements from their possible individual symbolic significances. The sum total response in each instance would be the individual E.P.R.T.

One effective and common defense against disaster is the rather primitive and magical defense of "denial" or assertion of personal invulnerability. Commonly one invokes such a thought as "yes, it might happen to someone else, but not to me." In effect, one becomes the all-powerful master of chance and fate. The threats of danger or death through chance, fate, and nature can thereby be dismissed. One could hardly function effectively if he dwelt too steadily on the prospects of death, which lies potentially around many corners. Thereby personal impotence in the relation to acts of nature or man is replaced by feelings of invulnerability or omnipotence. Repeated threats may damage the protective ability this affords so many people. This might be illustrated very briefly by the following case:

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* The usual dynamic position in this regard was well expressed by Deutsch[5] in describing the onset of neurotic symptoms following a psychologically traumatic experience: "... such traumatic experiences may well be the occasion for the outbreak of a neurosis, but they are extremely seldom the ultimate and only cause of the illness." Until I learn of a better example, I am willing to advance case 2 as my best 'candidate" for this "extremely seldom" type of case.

Case 3. *The cumulative destructive effect upon personal defenses by repeated traumatic misadventures.* A 29-year-old bombardier was relieved of his flying duties in a high state of nervous tension, asserting he could never fly again. The precipitating event was his having missed being aboard a plane when it crashed and burned on take-off with all lives lost. He had been sent to check on some missing gear by the pilot when the latter received immediate orders to take off slightly ahead of the scheduled time and without getting the missing man aboard. He had missed a flaming death by minutes and apparently by pure chance. While this might have had a considerable impact upon him in any event, it was more devastating as the fifth incident of a similar series taking place over a rather short space of time.

The significance of the cumulative effect upon his ego defenses was initially unclear. In view of the acuteness of this situation, several interviews were conducted under sodium amytal. The emotional abreaction was massive. It was quickly apparent that each traumatic event had dealt an increasingly effective blow at some of this patient's basic defenses. This man, under the cumulative effect of the traumatic events, had literally reversed his original omnipotent feelings of "it can't happen to me" to a reverse "omnipotence of responsibility"; i.e., he feels in effect, "this has happened because I was there—because of me; I am the jinx; therefore, I am responsible for the dread accident." One may note in this emotional assumption of an objectively irrational position, whereby his presence is somehow linked with the disaster, certain similarities to the "paranoid position" with its grandiose great power and importance. This is accompanied, of course, by what one may regard from one viewpoint as the accompanying price paid for this through the subjective suffering of what is then experienced as persecution.*

This patient had a considerable burden of guilt. Part of it was on the above rather "magical" basis of responsibility and additionally on the "buddy" or "unit guilt" seen not infrequently in combat and occasionally in civilian situations. Unit guilt is that guilty response to the death or injury of one's buddy or comrades. Large elements are often repressed from conscious awareness. As a result, unit guilt often substantially contributes to the emotional distress following the stress of combat. I have seen recall of these painful feelings especially during abreaction under narcosis and in analytic treatment. Evidence of its presence may sometimes also be ascertained in dream content. While deeper unconscious roots may be uncovered, leading into antecedent conflicts of early life, the precipitating situation is the feeling of responsibility toward the comrade. It is as though the survivor feels a guilty and nonrational need to share the fate of the lost buddy. At times there is underlying guilt over such pre-combat or combat feelings as, "if it has to be someone, let it be someone else!" or "I don't care who gets it just so it isn't me," "I'd rather even have my best friend Bill get hit than me," etc.

Variations of this theme of unit guilt have been observed by many psychiatrists. When the *U.S.S. Strong* was hit during early World War II, the communications officer and an assistant received verbal orders to go below into the officers' quarters and destroy secret codes and the keys for them. Any chance of these vital means for the enciphering and deciphering of messages falling into enemy hands had to be prevented at all costs. Tragically, events moved too rapidly and beyond control. Busy behind watertight compartment doors, the two officers never received word to abandon ship and were trapped there when she went down. Another officer who had been personally close to them subsequently suffered bitter feelings of unit guilt which were repressed from conscious awareness. Under analysis several years later access to these buried feelings was regained. During several painful sessions he expressed them, at the time also expressing his tearful wish to have been with them. It is as though the sharing of the fate of the lost comrade in unit guilt would be the ultimate penance extracted by an archaic and punitive super-ego for any hostile, selfish, or aggressive feelings which may have been present and deemed unworthy and intolerable. Finally, we might mention the rather superficial attempted defense against trauma, injury or loss by conscious rationalization. An example of this was stated several hundred years ago by Aesop, "There is always some one worse off than yourself."

During our discussion thus far, I have tried to stress the individuality of one's reaction to stress and trauma (the E.P.R.C. and the E.P.R.T.). One's entire past experience enters into this, predetermining in nonobvious fashion what reaction will occur following exposure to trauma. Such predetermination goes so far even as to influence the genesis of the trauma itself in the accident-prone individual, about which the interested student can learn more elsewhere.[8, 9] The relative presence or lack of personal security is also most highly individual. It has developed largely on the basis of prior experience in life and particularly through the vicissitudes of relationships with various important and significant people. Among the latter, those with the significant adults of childhood are the most vital because of their primordial position and antecedent role. Further, as pointed out in my earlier study on hypochondriasis,[10] the attitudes of parents toward themselves and toward their children play a vital role in the developing attitudes of the children toward themselves. Thus overprotectiveness, overcaution, and apprehensiveness on the part of parents often help to "condition" similar attitudes in the child.

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* The paranoid patient thereby achieves at terrible cost the illusory "attention' of people and a position of being important enough to them to become the "object" of what is to him their hostility, plotting, scheming, and efforts to destroy. Actually, his "gain" is usually less apparent than the price in suffering he simultaneously pays for it. This is only one aspect of a complex syndrome. For example, projection also plays an important role in the paranoid position.

It is to be noted that, particularly in industrial cases, there may be a time lag from minutes to months (occasionally even years) before the onset of symptoms, or before the patient has attributed responsibility for the difficulties to the earlier accident. There is another type of lag between injury and reaction which can often have a clearer physiologic explanation but into which I suspect additional important psychologic components sometimes enter. Some years ago I was watching a minor league baseball game in Narberth. In the fifth inning a man got safely on first. After 2 strike-outs the next batter suddenly hit a bad pitch down first baseline which struck the previous player a glancing blow on the head. The latter paused momentarily to size up the situation, saw the hit was a "fair" one, and then determinedly streaked to second base, after which he abruptly collapsed and was carried from the field.

I have observed similar incidents since then. While serving on the Beach Patrol at Stone Harbor there was a particular rescue in which a man had a narrow escape from drowning and did fine until after we pulled him from the surf and he was safe on the beach. Only then did he "fall apart at the seams," emotionally and physically, apparently making a complete recovery some hours later. More recently, during junior baseball tryouts at the same resort, the pleasurable occasion was marred when a bat was carelessly swung, striking another boy heavily in the head. The latter stood calmly for a short time and talked briefly almost as though he didn't yet realize he was injured. Then he slowly wilted and was rapidly transported to the hospital, where he fortunately made a prompt recovery.

These instances are cited to illustrate a particular kind of time-lag following trauma. Especially in the first 2, it is almost as though the E.P.R.C. is such as to enable the person to cope with the situation at hand before "giving in" to the trauma; or in the second instance as though one may collapse only after the real danger situation is over, when the need for emergency mobilization is past. The E.P.R.C. herein provides enough emergency energy to carry through the actual situation. The full impact of the danger or trauma is held in abeyance until the situational needs are met. Where this is operative, on given occasions its effect can be protective and life-saving. This is clearer when one notes how self-defeating can be the occasional irrational and sometimes agitated panic, or a helpless frozen state of fear in response to a crisis. It has been observed that frightened and panicked horses will run back into a blazing barn to their death, and that strong physical restraint may be necessary to prevent such disastrous action.

The emotional-physiologic response to trauma (E.P.R.T.) includes all types of symptoms and defenses and combinations of them. Every type or classification of neuroses has been observed to apparently follow some traumatic event as the precipitating cause. In discussing neuroses following head injuries, Schilder[11] reports that the most frequent group is of hysterics with the hypochondriacal-neurasthenic group perhaps next. My own experience would confirm this,* with anxiety reactions running a close third. Occasionally one sees a depressive reaction, more rarely a massive dissociation or phobic formation. Since, as Dr. Robert P. Knight† writes, "the simplest neurosis is anxiety hysteria (the phobias . . .)," it is perhaps surprising that more of these reactions are not seen.

Where the predisposition exists, an occasional post-traumatic retreat into obsessional preoccupation is seen. As a small boy I recall observing the then curious and puzzling response of the one motorist who had miraculously survived uninjured a major collision at a crossroads. We had come upon the smashed cars shortly after the accident and this man in torn and soiled clothes was standing by what was hardly any longer recognizable as a car, reciting repetitively how fortunate he was that his right foot had escaped injury. Despite his right shoe being torn off and mangled when the motor block was pushed back through the dashboard, his foot was unharmed. His preoccupation in obsessive fashion with this minor aspect of the tragic event was remarked upon curiously by several among the crowd of persons who had collected. Many years later I could recognize part of the evident protective intent in his obsessive pattern of reactions. By focusing his attention upon what was relatively speaking a trifle,‡ he avoided more serious and disturbing thoughts and emotions which might have arisen, for example, from contemplation of the lives lost, possible responsibility on his part, and perhaps the narrowness of the escape of his entire self and not just one small part. Obsessional preoccupation with various aspects of compensation for the injury is seen in some industrial and service cases.

When the person is not already psychologically conditioned for the onset of emotional disturbance, a severely traumatic experience is often well tolerated. Many servicemen suffered exposure to all varieties of traumatic war experiences and showed little appreciable effect. Their ability to adjust to war conditions has been eminently successful. Schonberger,[12] who described states of depersonalization during wartime, discussed this process of adaptation to traumatic circumstances as one in which a new "war ego" comes into existence.

In civilian life one can sometimes see contrasting examples where the possible sequelae to a serious single traumatic event in one case is overshadowed in another case where there has been instead an objectively minor similar traumatic experience following, however, years of conditioning by overcautious parents. Let me illustrate in the following case:

Case 4. *A traumatic experience with minimal sequelae.* The history was recently reported to me of a 12-year-old girl who was playing alone in the shallow water at the edge of a lake some years ago. She was unable to swim. Despite previous admonitions about such a possibility, she incautiously stepped backward off a ledge into deeper water. Fortunately, by dint of great effort she managed to extricate herself from a perilous situation. Despite the terrific threat, the drama and the close call which might have understandably precipitated various types of emotional difficulty in some persons, there was a minimum of emotional disturbance. She had one nightmare, was uneasy about the water for a few days, but went on shortly to learn to swim and has not been uneasy about water or swimming since.

Now let us contrast this case with the following instance:

Case 5. *Emotional disturbance following a slight traumatic event.* A 42-year-old man became anxious, sleepless, and had repeated disturbing dreams following a visit to the beach. A painfully cautious person around the water, he had a great uneasiness about it. He had never learned to swim and only went bathing on rare occasions upon his wife's insistence. On this occasion a wave had pushed him off balance when his attention was directed elsewhere.

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* This is reflected by my own earlier oversimplified definition of traumatic neurosis as "a special combination of situational conversion reaction and hypochondriasis." (M. Ann. District of Columbia, 1954, **23,** 100.)

† Personal communication, July 7, 1954.

‡ In discussing the defensive operations of obsessively oriented people, Lewis B. Hill notes appropriately that "the regular characteristic of these people (is) that they displace their concerns on to trifles." (Personal communication, June 29, 1954.)

In this instance there was a long history of overcaution and fear which had been protectively induced by his parents. He was one of the younger children in a large farm family. There was a fair-sized creek not too far from the house. Parents were busy, and also could not swim themselves. Their own best protection was to induce enough feeling in the small boy so he would simply keep a safe distance away from the creek. While this had proven eminently successful, he was left in adult life with a deeply established emotional reaction which in self-defeating fashion far exceeded its original protective intent. In this instance it is clear that the traumatic event was only of this level of significance to him because of the conditioning which took place during his early formative years.

As in the above case, long past events may result in a vulnerability to certain traumatic events or injuries as to constitute a veritable "emotional Achilles heel." Although trauma precedes the illness, may directly precipitate it and appear to cause it, in probably most instances the latter appearance is superficial, and further search where feasible will often disclose deeper dynamic roots. Such was the case in the following instance where, as Fenichel[13] stated in discussing traumatic neurosis, infantile conflicts are reactivated and "old infantile threats and anxieties suddenly reappear. . .":

Case 6. *The effects of a traumatic relationship are reënforced many times because of its early antecedents.* A young sergeant was admitted to the sick list following "a quarrel with the C. O." On examination he was tremulous, restless, and virtually in a state of panic. Initially he could give little information. From collateral sources it was learned that the major in his outfit had singled him out for a particularly abusive and violent "dressing down." This, it seems, had been the culminating event in a long unsatisfactory relationship between the two men, punctuated by a series of similar incidents.

The major was a man of violent temper given to bursts of rage in which he was apt to abuse someone he felt had fallen short in the line of duty. He indulged heavily in alcohol, at which times these tendencies were magnified. Other men had also served as objects of his wrath, but apparently without undue effect. Perhaps they had been able to "shrug it off." Not so with the sergeant. It was as though his very vulnerability had unwittingly resulted in further destructive deterioration of the relationship and only served to unwittingly "invite" incidents.

In résumé, the sergeant's father had been an abusive, violent-tempered alcoholic given to physical assaults on the patient's mother and occasional beatings of the son prior to his deserting them permanently when the patient was 9. During treatment the parallels between these relationships became increasingly apparent. The patient had seemingly "forgotten" the many conflicts consequent to his early years. They had, however, become reactivated and old anxieties rekindled by what amounted to him symbolically a reconstitution of the earlier desperate threats and conflicts in his desperately unfortunate relationship with his father. These and certain other areas were clarified in so far as possible with the patient in an intensive therapeutic regimen with limited goals, during which he made substantial gains. He was returned to duty with a new outfit where his adjustment was excellent during a number of succeeding months while contact continued possible.

DYNAMICS

My preference for a definition of neuroses following trauma would at this point describe them as "those neurotic reactions where the source has been attributed to a specific situational traumatic event which may be physical, emotional, or both. The dynamics, where ascertainable, will in nearly every case reveal some special individual significance for the circumstances or event already present for, or gained subsequently by the patient." Much has been said or implied already about the dynamics, and in this section I will amplify these data and bring in some selected contributions from the many scattered references.

Sigmund Freud has made a number of contributions to the subject. He[7] early called attention to the patient's emotional fixation to the time of the trauma and recognized what is often a diagnostic criterion in the subsequent reproduction of the traumatic situation in dreams. This latter is an especially frequent factor in emotional reactions following combat and in those following acute, overwhelming traumatic experiences in civilian life In discussing the unconscious wish and significance of a misstep or slip, Freud[14] commented on the onset of nervous ailments following a fall without injury, and noted "that the fall was already a preparation of the neurosis. . . ." He[7] also said that hysterical attacks may occur in which "the attack constitutes a complete reproduction of this (the traumatic) situation."

In "Inhibitions, Symptoms and Anxiety" Freud[6] discussed anxiety in relation to danger and traumatic situations in which he regarded anxiety as the signal for the avoidance of a danger situation. Further, this is an automatic phenomenon and a product of helplessness. The infant's mental helplessness is a counterpart of biologic helplessness. Whereas the later danger to the child is separation from the very necessary person who gratifies his vital needs, the original (primordial) danger was separation at birth. Finally, in the "New Introductory Lectures" Freud[15] noted the two-fold origin of anxiety, "first, as the direct effect of a traumatic factor, and, secondly, that a traumatic factor . . . threatens to recur." Perhaps it should be noted here for purposes of clarity that Freud is using "traumatic" in a much wider sense than that of the narrower definition proposed for this discussion. According to Freud,[15] in the wider sense, ". . . what is feared, the object of the anxiety, is always the emergence of a traumatic factor. . . ."

Trauma may include every conceivable type of physical or psychologic injury. The latter includes separation, moves, deaths, financial disaster, losses of office, position, prestige, and divorce. Neuroses may occur post-illness, post-operatively, and post-combat. Recently I saw the outward indications of considerable emotional distress following the sudden appreciation of some of the real implications of a serious suicidal attempt:

Case 7. *The "traumatic impact" of gaining awareness of some of the implications of a serious suicidal attempt.* A 33-year-old married mother of 4 young children was referred for evaluation and recommendation following a suicidal attempt. I believe it is always wise to regard every such case as an emergency until proven otherwise, a practice which I am personally sure has contributed to my extraordinary good fortune in the management of many severely depressed patients throughout a reasonably extensive psychiatric experience. Prompt and decisive action is vital to the successful management of these cases. Indecision, delay, and temporizing can be literally fatal and is never really a kindness at all to the patient or to the patient's family. In this case the following of these principles resulted in seeing her in emergency consultation, which proved well worthwhile. There was no question of moderate depression being present. Further, the suicidal attempt was not impulsive, nor was there any real remorse present, both being factors which I have learned to regard and have earlier reported[16] as having practical importance as regards (1) the seriousness of the suicidal attempt, (2) the danger of a repeated (and perhaps more successful) effort, and (3) the prognosis more generally. At one point the patient expressed her regrets that her attempt had failed, adding, "It just goes to prove I'm a failure at everything; I couldn't even do a decent job of killing myself."

After careful assessment of these and other factors in the case, I advised immediate hospitalization, and the patient raised few objections until it occurred to her that her husband would then have charge of the children during her absence, and this she couldn't stand. According to her view, her husband was not able to do a good job. Furthermore, she regarded his whole attitude toward the children as unkind. To point out the inconsistency of this objection with her suicidal attempt, by which she might have left them permanently in his hands, I commented dryly that this consideration had not seemingly deterred her a few hours earlier.

The patient's reaction was as though she were stunned. Apparently the real impact of some of the serious consequences of what had narrowly missed being her demise suddenly struck her. Seemingly she had at this point first realized the seriousness and permanence of such an act. Part of this must have been defensively maintained out of awareness, and the rush into consciousness brought recognition of additional conflicts. The emotional response to this bit of insight as observed was somewhat comparable to that following some more clearly specific traumatic experiences. In this instance, however, the net result was decidedly therapeutic and helped establish a favorable attitude toward hospitalization and laid some of the early foundation for the successful therapeutic work which ensued.

This incident also helps point up some of the very practical reasons why patients resist therapy. The recognition of previously hidden or

(*Continued on page 548*)

First
INTERSTATE SCIENTIFIC ASSEMBLY

SHOREHAM HOTEL WASHINGTON, D. C., NOV. 1-2-3, 1954

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

THE MEDICAL SOCIETY OF VIRGINIA

ANOTHER MILESTONE

FOR the first time in their history, the Medical Society of the District of Columbia and the Medical Society of Virginia have abandoned their annual scientific sessions for a joint meeting to be held in Washington, D. C.

This is a unique occasion and one which will undoubtedly not be repeated for several years. It is therefore my sincere hope that every member of our Society will take part in all or some of the scientific sessions during the First Interstate Scientific Assembly. It is equally important that they take full advantage of the opportunity to fraternize with their fellow physicians from Virginia.

To those Virginia physicians who read these lines I extend a cordial welcome to the Nation's Capital. We are most happy that through the pooled resources of both our organizations this will be the outstanding medical event of the year in Washington.

Preston A. McLendon

First Interstate Scientific Assembly

SCIENTIFIC PROGRAM

All Sessions at the Shoreham Hotel

MONDAY, NOVEMBER 1—MORNING SESSIONS

TERRACE BANQUET ROOM

Preston A. McLendon, M.D., *Presiding*
President, The Medical Society of the District of Columbia

9:20–9:30 Addresses of Welcome

9:30–11:00 Symposium on Juvenile Delinquency

Addison M. Duval, M.D., *Moderator*
Assistant Superintendent, St. Elizabeths Hospital; Clinical Professor of Psychiatry, George Washington University School of Medicine, Washington, D. C.

9:30–9:50 Birth through Five Years

Leo Kanner, M.D.
Associate Professor of Psychiatry and Pediatrics, Johns Hopkins University School of Medicine, Baltimore, Md.

9:50–10:10 Five Years to Adolescence

Frank J. Curran, M.D.
Director, Children's Service Center of Charlottesville and Albemarle County, Inc., Charlottesville, Va.

WEST BALLROOM

Vincent W. Archer, M.D., *Presiding*
President, The Medical Society of Virginia

9:00–9:30 Addresses of Welcome

9:30–12:00 A Critical Appraisal of Certain Current Medical Therapies

9:30–9:50 Vitamins, Hematinics and Transfusions

Charles M. Caravati, M.D.
Associate Professor of Clinical Medicine, Medical College of Virginia, Richmond, Va.

9:50–10:10 Uses and Abuses of Hormone Therapy

William Parson, M.D.
Professor and Head of Department of Internal Medicine, University of Virginia School of Medicine, Charlottesville, Va.

10:10–10:30 Antibiotic Therapy

Count Dillon Gibson, Jr., M.D.
Assistant Professor of Medicine, Medical College of Virginia, Richmond, Va.

10:30–11:00 Intermission to Visit Exhibits

Night View of the United States Capitol

TERRACE BANQUET ROOM

10:10–10:30 ADOLESCENCE

Fritz Redl, Ph.D.

Chief, Child Research, Children's Service, National Institute of Mental Health, The Clinical Center, Bethesda, Md.

10:30–10:50 DISCUSSION PERIOD

10:50–11:20 INTERMISSION TO VISIT EXHIBITS

11:20–11:40 PEDIATRIC ALLERGY

Susan Coons Dees, M.D.

Associate Professor of Pediatrics and Allergy, Duke University School of Medicine, Durham, N. C.

11:40–12:00 THE HANDICAPPED CHILD

G. G. Deaver, M.D.

Professor of Physical Medicine and Rehabilitation, New York University College of Medicine; Medical Director of Children's Service, Institute of Physical Medicine and Rehabilitation, New York, N. Y.

12:00–2:00 RECESS FOR LUNCHEON

WEST BALLROOM

11:00–11:20 LENTE INSULIN IN THE TREATMENT OF DIABETES

Alexander Marble, M.D.

Clinical Associate in Medicine, Harvard Medical School; Physician, Joslin Clinic and New England Deaconess Hospital, Boston, Mass.

11:20–11:40 RADIOISOTOPES IN HEART DISEASE AND CANCER

B. J. Duffy, Jr., M.D.

Instructor in Medicine and Director of the Isotope Laboratory, Georgetown University School of Medicine, Washington, D. C.

11:40–12:00 DISCUSSION PERIOD

12:00–2:00 RECESS FOR LUNCHEON

THE MEDICAL SOCIETY OF THE

Home of the District Medical Society

MONDAY, NOVEMBER 1—AFTERNOON SESSIONS

TERRACE BANQUET ROOM

David S. Garner, M.D., *Presiding*

First Vice President, The Medical Society of Virginia

2:00–2:20 CURRENT MEDICAL LEGISLATION

Frank E. Wilson, M.D.

Director, Washington Office, American Medical Association, Washington, D. C.

WEST BALLROOM

Paul R. Wilner, M.D., *Presiding*

First Vice President, The Medical Society of the District of Columbia

2:00–4:30 A CRITICAL APPRAISAL OF CERTAIN CURRENT SURGICAL THERAPIES

2:00–2:15 TONSILLECTOMIES

Victor R. Alfaro, M.D.

Professor of Otolaryngology, Georgetown University School of Medicine, Washington, D. C.

TERRACE BANQUET ROOM

2:20–2:40 Union Welfare Funds and the Doctors

William A. Sawyer, M.D.

Chairman, A.M.A. Committee on Medical Care for Industrial Workers; Medical Consultant to the International Association of Machinists, Rochester, N. Y.

2:40–3:00 Question and Answer Period

3:00–3:30 Intermission to Visit Exhibits

3:30–4:30 Panel Discussion on Medical Expense Plans

Donald Stubbs, M.D., *Moderator*

President, Medical Service of the District of Columbia, Washington, D. C.

Frank E. Smith

Director, Blue Shield Medical Care Plans, Chicago, Ill.

W. H. Horton

Executive Director and Director of Medical Service, Inc., New Haven, Conn.

James Andrews, Jr.

Director of Health Insurance, Life Insurance Association of America, New York, N. Y.

Question and Answer Period

* Speakers indicated by an asterisk appear on the program by courtesy of the District of Columbia and the Virginia Divisions of the American Cancer Society.

WEST BALLROOM

2:15–2:30 Breast Cysts

Ernest A. Gould, M.D.

Instructor in Surgery, George Washington University School of Medicine; Attending Surgeon, Garfield Memorial Hospital, Washington, D. C.

2:30–2:45 Extraction of Teeth

Daniel F. Lynch, D.D.S., Washington, D. C.

President, American Dental Association

2:45–3:00 Sterilization

John E. Savage, M.D.

Assistant Professor of Obstetrics, University of Maryland School of Medicine, Baltimore, Md.

3:00–3:30 Intermission to Visit Exhibits

3:30–3:50 The Indications for Adrenalectomy

H. A. Zintel, M.D.*

Associate Professor of Surgery, University of Pennsylvania School of Medicine and Graduate School of Medicine, Philadelphia, Penna.

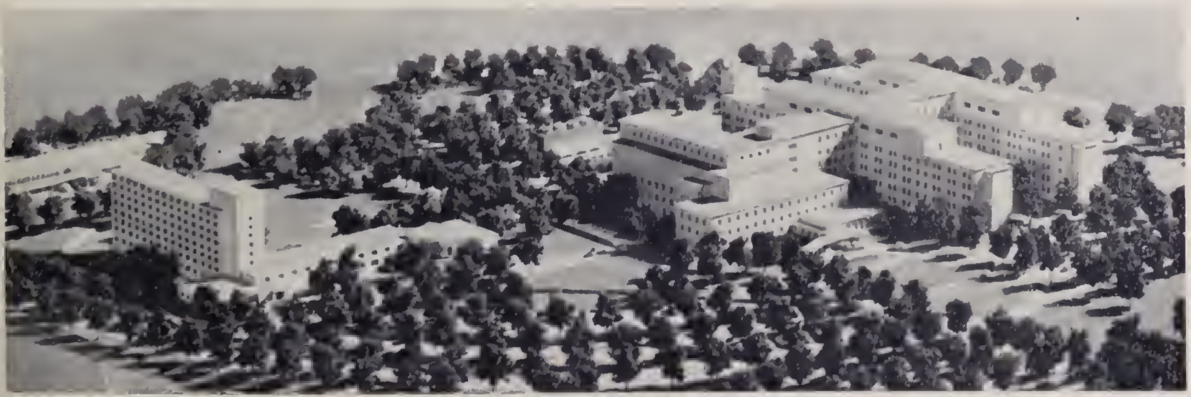
3:50–4:30 Round Table Discussion on the Above Subjects

John Wyatt Davis, Jr., M.D.

Lynchburg, Va.

Carson Lee Fifer, M.D.

Chief of Surgery, Alexandria Hospital and Circle Terrace Hospital, Alexandria, Va.



New Hospital Center, Washington

TUESDAY, NOVEMBER 2—MORNING SESSIONS

TERRACE BANQUET ROOM

A. Tyree Finch, M.D., *Presiding*

Third Vice President, The Medical Society of Virginia

9:00–9:10 GERIATRIC GYNECOLOGY

Newlin F. Paxson, M.D.

Professor and Head, Division of Women, Hahnemann Medical College and Hospital, Philadelphia, Penna.

9:10–9:20 BACKACHE AND DYSMENORRHEA

Robert N. Creadick, M.D.

Associate Professor of Obstetrics and Gynecology, Duke University School of Medicine, Durham, N. C.

9:20–10:00 PANEL DISCUSSION ON ABOVE SUBJECTS

W. R. Payne, M.D.

Chief Attending Obstetrician and Gynecologist, Riverside and Mary Immaculate Hospitals, Newport News, Va.

Robert H. Barter, M.D.

Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine, Washington, D. C.

10:00–10–30 INTERMISSION TO VISIT EXHIBITS

10:30–10:40 INDUCTION OF LABOR

C. Hampton Mauzy, M.D.

Associate Professor of Obstetrics and Gynecology, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C.

10:40–10:50 THE RELATIONSHIP OF ESSENTIAL HYPERTENSION TO PREGNANCY

Robert Landesman, M.D.

Department of Obstetrics and Gynecology, New York Lying-in Hospital, New York, N. Y.

WEST BALLROOM

Margaret M. Nicholson, M.D., *Presiding*

Second Vice President, The Medical Society of the District of Columbia

9:00–9:20 THE PRESENT STATUS OF ANTI-HYPERTENSIVE DRUGS

Edward D. Freis, M.D.

Assistant Chief of Medicine, Veterans Administration (Mount Alto) Hospital, Washington, D. C.

Home of the Virginia Medical Society

9:20–9:40 THE PRESENT MANAGEMENT OF ARTHRITIS

Charles Ragan, M.D.

Associate Professor of Medicine, College of Physicians and Surgeons, Columbia University, New York, N. Y.

TERRACE BANQUET ROOM

10:50–11:30 Panel Discussion on Above Subjects

W. N. Thornton, Jr., M.D.
Professor of Obstetrics and Gynecology, University of Virginia School of Medicine, Charlottesville, Va.

Frank A. Finnerty, Jr., M.D.
Chief, Cardiovascular Research, Georgetown Division, District of Columbia General Hospital, Washington, D. C.

11:30–12:00 Presentation of Awards

The Medical Society of the District of Columbia:
- Certificate of Meritorious Service
- John Benjamin Nichols Award
- Scientific Exhibit Awards

The Medical Society of Virginia:
- The 50-Year Club Awards

Installation of **Carrington Williams, Sr., M.D.** as President of the Medical Society of Virginia

12:00–2:00 Intermission for Luncheon

WEST BALLROOM

9:40–10:00 The Use of the Newer Antibiotics

Monroe J. Romansky, M.D.
Associate Professor of Medicine, George Washington University School of Medicine; Chief, George Washington University Division, District of Columbia General Hospital, Washington, D. C.

10:00–10:30 Intermission to Visit Exhibits

10:30–10:50 The Significance of Nodular Goiter

John C. McClintock, M.D.*
Assistant Professor of Surgery, Albany Medical College, Albany, N. Y.

10:50–11:10 The Medical Treatment of Thyroid Diseases

E. C. Bartels, M.D.
Internist, Lahey Clinic, Boston, Mass.

11:10–11:30 Discussion Period

11:30–12:00 Presentation of Awards in Terrace Banquet Room

TUESDAY, NOVEMBER 2—AFTERNOON SESSIONS

TERRACE BANQUET ROOM

2:00–2:30 The Davidson Lecture: The Physiology of Arteriovenous Fistulas

George E. Schreiner, M.D.
Director of the Renal Service, Georgetown University School of Medicine, Washington, D. C.

The Davidson Lecture was established May 1, 1929, as an enduring expression of the gratitude of The Medical Society of the District of Columbia to Edward Young Davidson, M.D., who, when President of the Society in 1916, conceived and led to completion the erection of its building at 1718 M Street, N.W., Washington, D. C.

WEST BALLROOM

James W. Love, M.D., *Presiding*
Co-chairman, Committee on Arrangements, First Interstate Scientific Assembly, Alexandria, Va.

2:30–2:50 The Treatment of Urinary Tract Infections

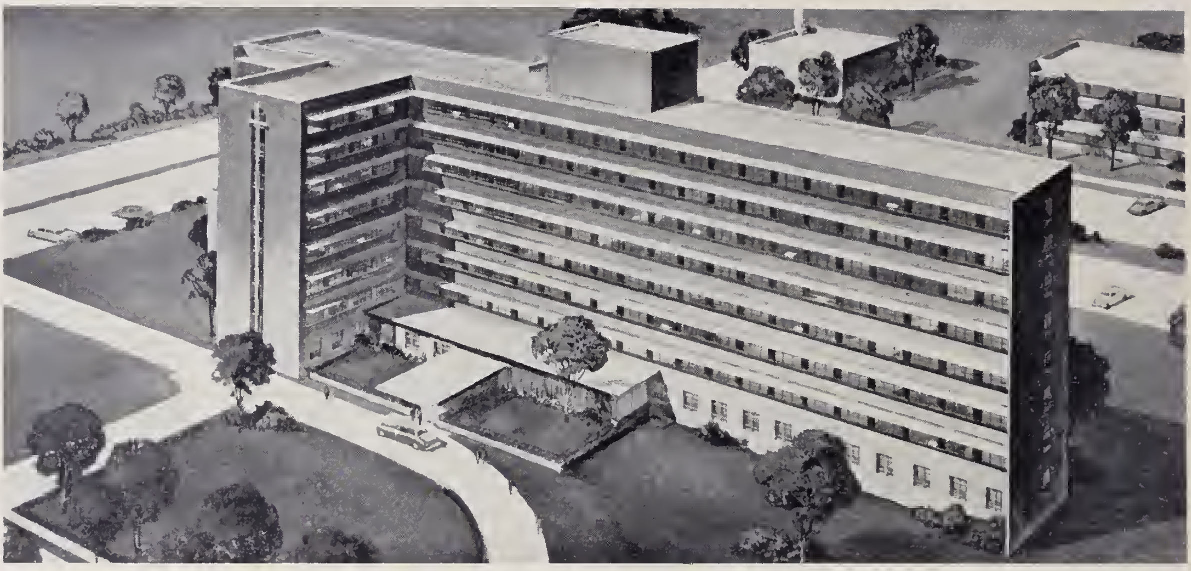
Charles A. W. Uhle, M.D.
Professor of Urology, University of Pennsylvania School of Medicine, Philadelphia, Penna.

2:50–3:10 The Treatment of Enlarged Prostates

Samuel A. Vest, M.D.
Professor of Urology, University of Virginia School of Medicine, Charlottesville, Va.

3:10–3:30 The Significance of Hematuria

Austin I. Dodson, M.D.
Professor of Urology, Medical College of Virginia, Richmond, Va.



New Providence Hospital, Washington

TERRACE BANQUET ROOM

Frank E. Tappan, M.D., *Presiding*

Second Vice President, The Medical Society of Virginia

2:30–2:50 A CRITICAL EVALUATION OF CLINICAL LABORATORY TESTS

L. A. Rapee, M.D.

Attending Physician, Garfield Memorial Hospital, Washington, D. C.

2:50–3:10 CYTOLOGY AS A PRACTICAL DIAGNOSTIC AID

Grace H. Guin, M.D.

Associate Pathologist, Children's and Garfield Memorial Hospitals, Washington, D. C.

3:10–3:30 INDICATIONS FOR AND INTERPRETATIONS OF BIOPSIES

WEST BALLROOM

Arthur Purdy Stout, M.D.*

Professor of Surgery Emeritus. College of Physicians and Surgeons, Columbia University New York, N. Y.

3:30–4:30 CLINICAL PATHOLOGICAL CONFERENCE

Thomas M. Peery, M.D., *Moderator*

Professor of Pathology, George Washington University School of Medicine, Washington, D. C.

George T. Harrell, M.D.

Dean, College of Medicine, University of Florida, Gainesville, Fla.

WEDNESDAY, NOVEMBER 3—MORNING SESSION

TERRACE BANQUET ROOM

Ralph M. Caulk, M.D., *Presiding*

Chairman, Committee on Arrangements, FIRST INTERSTATE SCIENTIFIC ASSEMBLY, Washington, D. C.

9:00–9:20 CANCER DETECTION: THEORETICAL AND PRACTICAL DIVIDENDS

Charles S. Cameron, M.D.*

Medical and Scientific Director and Vice President, American Cancer Society, Inc., New York, N. Y.

9:20–9:40 CANCER DETECTION IN RURAL GENERAL PRACTICE
D. J. Miller, Jr., M.D.*
Morgantown, Ky.

9:40–10:00 THE INDICATIONS FOR THE USE OF SUPERVOLTAGE IRRADIATION
Ralph Phillips, M.D.*
Associate Radiotherapist, Memorial Center for Cancer and Allied Diseases, New York, N. Y.

10:00–10:20 CANCER CHEMOTHERAPY
J. Bateman, M.D.
Associate Oncologist, Garfield Memorial Hospital, George Washington University Cancer Clinic, Washington, D. C.

10:20–11:10 DISCUSSION PERIOD

11:10–11:30 INTERMISSION TO VISIT EXHIBITS

11:30–12:00 THE COUNTY SOCIETY, ITS RESPONSIBILITIES AND DUTIES
Walter B. Martin, M.D., Norfolk, Va.
President, American Medical Association

12:00–2:00 RECESS FOR LUNCHEON

WEDNESDAY, NOVEMBER 3—AFTERNOON SESSION

TERRACE BANQUET ROOM

T. Winship, M.D., *Presiding*

Chairman, Program Committee, FIRST INTERSTATE SCIENTIFIC ASSEMBLY, Washington, D. C.

2:00–2:20 PREVENTIVE MEDICINE
Hugh H. Hussey, M.D.
Professor and Head of the Department of Preventive Medicine and Public Health, Georgetown University School of Medicine, Washington, D. C.

2:20–2:40 THE SURGEON'S ROLE IN THE PUBLIC HEALTH PROGRAM
Owen H. Wangensteen, M.D.*
Professor of Surgery, University of Minnesota Medical School, Minneapolis, Minn.

2:40–3:00 PREVENTIVE GYNECOLOGY
D. Anthony D'Esopo, M.D.*
Professor of Clinical Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University, New York, N. Y.

3:00–3:30 INTERMISSION TO VISIT EXHIBITS

3:30–4:30 PANEL DISCUSSION: WHAT TO TELL THE CANCER PATIENT
C. T. Klopp, M.D., *Moderator*
Clinical Professor of Surgery, George Washington University School of Medicine, Washington, D. C.

Alec Horwitz, M.D.
Associate Professor of Surgery, George Washington University School of Medicine, Washington, D. C.

The Reverend Edmund J. Lee, D.D.
Shepherdstown, West Virginia

The Very Reverend Francis B. Sayre, Jr.
Dean of Washington Cathedral, Washington, D. C.

Arthur M. Sutherland, M.D.*
Chief, Department of Rehabilitation and Psychiatry, Memorial Center for Cancer and Allied Diseases, New York, N. Y.

Owen H. Wangensteen, M.D.*
Professor of Surgery, University of Minnesota Medical School, Minneapolis, Minn.

H. Mason Welch, LL.B., M.P.L.
Malpractice Defense Trial Counsel, Washington, D. C.

The Scientific Exhibit

All Exhibits at the Shoreham Hotel

WEST LOBBY

Space 1

Treponemal Immobilization Studies

COMDR. V. E. MARTENS, (MC) USN, AND LT. (J.G.) R. K. LEDBETTER, (NSC) USN, Naval Medical School, National Medical Center, Bethesda, Md.

Space 2

The Internal Architecture of the Femur from the Clinical Standpoint

WILLIAM J. TOBIN, M.D. AND MARVIN M. GIBSON, M.D., Georgetown University School of Medicine, Smithsonian Institution, and Armed Forces Institute of Pathology, Washington, D. C.

Space 3

Extended Resection for Cancer—Distal Colon and Rectum

GARNET W. AULT, M.D., ROBERT S. SMITH, M.D., AND ALEJANDRO F. CASTRO, M.D., Proctology Clinic of Washington, D. C.

Space 4

Diseases of the Thyroid Gland

GORDON R. HENNIGAR, M.D., AND SAUL KAY, M.D., Departments of Pathologic Anatomy and Surgical Pathology, Medical College of Virginia, Richmond, Va.

Space 5

Safe, Prolonged Muscle Relaxation in Orthopedics

EUGENE G. LIPOW, M.D., Washington, D. C.

Space 6

Radical Treatment of Paraplegic Pressure Sores

J. TREACY O'HANLAN, M.D., Waynesboro, Va.

Space 7

Problems in Legal Medicine

GEOFFREY T. MANN, M.D., LL.B., Richmond, Va.

Space 8

Coronary Disease in Young American Males

MAJOR WILLIAM F. ENOS, (MC) USA, AND CAPTAIN JAMES C. BEYER, (MC) USA, Armed Forces Institute of Pathology, Washington, D. C.

Space 9

Peripheral Vascular Diseases, Arterial, Venous and Lymphatic

EUGENE LOWENBERG, M.D., Norfolk, Va.

Space 10

Diseases of the Ear Drum

IRVIN HANTMAN, M.D., Washington, D. C.

WEST BALLROOM FOYER

Space 11

Breath Sounds on Tape

ROBERT J. ANDERSON, M.D., AND ARMAND E. BRODEUR, M.D., U.S.P.H.S.; WILLIAM B. WALSH, M.D., Georgetown University School of Medicine; ROBERT GRUVER, M.D., AND FAHRAN BAKIR, M.D., District of Columbia General Hospital, Washington, D. C.

Space 12

Alcoholism

Washington Committee for Education on Alcoholism, Washington, D. C.

Space 13

A Dynamic Brachial Plexus; Anatomy and Motor Function

COLONEL H. B. LUSCOMBE, (MC) USA, AND CAPTAIN JOEL L. ROTH, (MC) USA, Walter Reed Army Medical Center, Washington, D. C.

TERRACE BANQUET ROOM FOYER

Space 14

Etiology of Malpractice

Bureau of Exhibits, American Medical Association, Chicago, Ill.

Space 15

Abrasive Surgery

MURRY M. ROBINSON, M.D., Washington, D. C.

Space 16

Congenital Anomalies of the Gastrointestinal Tract

WILLIAM B. HOOVER, M.D., AND WILLIAM B. WILEY, M.D., Norfolk, Va.

Space 17

Control of House Dust Allergens

ELOISE W. KAILIN, M.D., Washington, D. C.

Space 18

Recent Advances in the Treatment of Intestinal Obstruction

JOHN DEVINE, JR., M.D., Lynchburg, Va.

Space 19

Hydrocortisone Topical Ointment in Dermatology

JAMES Q. GANT, JR., M.D., Washington, D. C.

Space 20

Infections of the Hand

Philip O. Caulfield, M.D., and Howard S. Madigan, M.D., Washington, D. C.

Space 21

A Dynamic Lumbosacral Plexus; Anatomy and Motor Function

Lt. Col. John H. Kuitert, (MC) USAF, Brooke Army Medical Center, Fort Sam Houston, Texas; Lt. Col. Joseph W. Thomas, (MC) USA, and Captain Frederick E. Vultee, (MC) USA, Walter Reed Army Medical Center, Washington, D. C.

Space 22

Homozygous Hemoglobin C: A New Hereditary Hemolytic Syndrome

Charles E. Rath, M.D., and Douglas W. Terry, M.D., Georgetown University Hospital, Washington, D. C

Space 23

The Symptoms of Diabetes Mellitus

James M. Moss, M.D., Georgetown University School of Medicine, Washington, D. C.

Space 24

Hysterosalpingography: Diagnostic Aid

J. B. Sheffery, M.D., and D. Kushner, M.D., Washington, D. C.

Space 25

External, Anterior Segment and Fundus Diseases of the Eye

Richard W. Wilkinson, M.D., Department of Ophthalmology, George Washington University, Washington, D. C.

Space 26

Getting Country Doctors

Edgar J. Fisher, Jr., Virginia Council on Health and Medical Care, Richmond, Va.

Space 27

Periarthritis Calcarea

Bela Gondos, M.D., Washington, D. C.

Space 28

Clinical Value of the Electroencephalogram

J. P. Murphy, M.D., and Elizabeth Braum, Technician, Washington, D. C.

Space 29

Concomitant Disease of Skin and Bone

Department of Dermatology, Medical College of Virginia; Carl S. Lingamfelter, M.D., and Allen Pepple, M.D., Richmond, Va.

Space 30

The Physician's Responsibility in the Prevention of Traffic Accidents

Cary N. Moon, Jr., M.D., and Fletcher D. Woodward, M.D.; E. C. Corey, M.D., University of Virginia Hospital, Charlottesville, Va.

Space 31

Herpangina and Infectious Gingivostomatitis

Robert H. Parrott, M.D., National Microbiological Institute, National Institutes of Health, Bethesda, Maryland; Research Foundation of Children's Hospital of the District of Columbia

Space 32

Thoracic Surgical Emergencies in the Newborn

Alvin C. Wyman, M.D., Marshall C. Sanford, M.D., and George Maksim, M.D., Children's Hospital of the District of Columbia

Space 33

Staphylococcal Enteritis Following Use of Broad Spectrum Antibiotics

Sydney M. Ross, M.D., Frederic G. Burke, M.D., and E. Clarence Rice, M.D., Children's Hospital of the District of Columbia

Space 34

Advances in the Treatment of Leukemia in Children

E. Clarence Rice, M.D., Charles B. Preacher, M.D., and Grace H. Guin, M.D., Children's Hospital of the District of Columbia

Space 35

A Study of Accidental Poisonings in Children and the Operation of a Center for the Control of Such Poisonings

Allen B. Coleman, M.D., Children's Hospital of the District of Columbia

Space 36

Solitary Masses in the Neck of Adults

G. H. Klinck, M.D., Armed Forces Institute of Pathology, C. T. Klopp, M.D., George Washington University Hospital, and T. Winship, M.D., Garfield Memorial Hospital, Washington, D. C.

Space 37

Esophageal Reconstruction by Esophagojejunostomy and Esophagocologastrostomy

Lewis H. Bosher, Jr., M.D., Alfred M. Decker, Jr., M.D., and Jaquelin M. Harrison, M.D., Medical College of Virginia Hospital, Richmond, Va.

Space 38

Late Effects—Internally Deposited Radioactive Material

Lt. W. B. Looney, (MC) USN, and Lt. (j.g.) Martin Colodzin, (MC) USN, Naval Hospital, National Naval Medical Center, Bethesda, Md.

Space 39

Evaluating the Patient's Abilities

A. B. C. Knudson, M.D., Joseph van Schoick, and Thomas J. Zwierlein, Veterans Administration, Washington, D. C.

WEST LOBBY

Space 40

Myocarditis: A Frequent Complication of Systemic Diseases: William C. Manion, M.D., Armed Forces Institute of Pathology and Veterans Administration, Washington.

Space 41

The Story of Gallstones: Paul L. Shallenberger, M.D., Donald M. Clough, M.D., and Henry M. Perry, M.D., Guthrie Clinic, Sayre, Penna. *(by special invitation)*

Medical Motion Pictures

All Motion Pictures at Shoreham Hotel

FOYER TO MAIN BALLROOM

MONDAY, NOVEMBER 1, 1954

Time	*Titles*	*Sponsors*
9:00	Intra-articular Injections of hydrocortisone	William B. Rawls, M.D., New York, N. Y.
9:30	Reproduction of the Rat	R. J. Blandau, M.D., and Anthony Conedo, M.D., University of Washington School of Medicine, Seattle, Wash.
9:50	Intravenous Anesthesia with Barbiturates	Mary Karp, M.D., W. O. McQuiston, M.D., and J. E. Remlinger, M.D., Chicago, Ill.
10:30	Effect of Reserpine on Monkeys	Alfred E. A. Earl, M.D., Summit, N. J.
10:45	Ovarian Tumors	Herbert E. Schmitz, M.D., Chicago, Ill.
11:15	Nephrosis in Children	R. E. Cooke, M.D., Yale University School of Medicine, New Haven, Conn., and Leo L. Leveridge, M.D., New York, N. Y.
11:40	Examining the Well Child	Oklahoma State Department of Health, Oklahoma City, Okla.
2:00	BCG . . . Vaccination Against Tuberculosis	National Tuberculosis Association, Chicago, Ill., and Research Foundation, American Trudeau Society, New York, N. Y.
2:20	Viral Hepatitis	Army Medical Service, Washington, D. C.
2:40	Principles of Fracture Reduction	Veterans Administration, Washington, D. C.
3:15	Pheochromocytoma	Keith S. Grimson, M.D., Duke University School of Medicine, Durham, N. C.
3:40	The Surgical Treatment of Mitral Stenosis	Bailey Thoracic Clinic, Philadelphia, Penna.
4:00	Encore Hour	

A limited number of films will be reshown as determined by the greatest number of requests.

TUESDAY, NOVEMBER 2, 1954

Motion pictures produced by the members of the Medical Society of the District of Columbia and the Medical Society of Virginia. All authors will be present during the presentation of their films. Time will be allowed for comment and discussion.

Time	*Titles*	*Sponsors*
9:00	Orchiopexy, Modified Torek Technic	Lloyd G. Lewis, M.D., Washington, D. C.
9:20	Ureterosigmoidostomy, A Simplified Technic	W. C. Stirling, M.D., and Charles H. Ligon, M.D., Washington, D. C.
9:45	Transorbital Lobotomy: Part III, Anxiety	Walter Freeman, M.D., Los Altos, Calif.
10:15	Plastic Reconstruction of Agenesis of the Vagina	Alfred J. Suraci, M.D., Washington, D. C.
10:40	Direct Intracardiac Surgery with General Hypothermia	Edgar W. Davis, M.D., Charles E. Fierst, M.D., John O. Nestor. M.D., and Bernard J. Walsh, M.D., Washington, D. C.
11:00	Intramedullary Nail for Fracture of Femur	Virgil R. May, Jr., M.D., Richmond, Va.
11:20	Spinal Fusion	William M. Deyerle, M.D., Richmond, Va.
2:00-4:00	Special Showing of Newest Medical Films Released Too Late for Programming	

WEDNESDAY NOVEMBER 3, 1954

Monday Program Will Be Repeated

AAGP Participation

Both the District of Columbia and Virginia Chapters of the American Academy of General Practice have notified their members that the FIRST INTERSTATE SCIENTIFIC ASSEMBLY has the official sanction of the Commission on Education of the American Academy of General Practice for formal postgraduate credit to Academy members who attend this meeting.

In view of the active interest in the ASSEMBLY of officers of both Chapters it is expected that there will be a large attendance by general practitioners.

Dinner for Doctors' Office Staffs

One of the most successful events of last year's ASSEMBLY was the dinner for doctors' office staffs (nurses, secretaries, technicians, receptionists, etc.). It was, therefore, decided by the Committee on Arrangements to make this an annual affair.

This year's dinner is sponsored jointly by the Medical Societies of the District of Columbia and Virginia.

Leo E. Brown, Director of Public Relations, American Medical Association, will be the speaker; his subject, "You Can Be a Star on Medicine's PR Team." Entertainment will be furnished by doctors and their wives from the District of Columbia and Virginia, among whom there is exceptional talent.

As in previous years, physicians will be asked to purchase tickets for the dinner for their office staffs. Tickets will be $5.00 each, the actual cost of the dinner. Tables will be filled as applications are received; *individuals or groups wishing to sit at the same table should send in their requests together*. Changes cannot be made after seating has been arranged.

Tickets will be mailed on receipt of application and check at the offices of the Medical Society of the District of Columbia, 1718 M Street, N.W., Washington 6, D. C.

Main Lobby, Shoreham Hotel

Alumni Dinners and Luncheons

The time and place of all alumni dinners and luncheons are to be found listed in the Assembly Calendar on pages 518 and 519. Tickets for these events will be available either through the officers of the sponsoring groups or in the Registration Section.

Women's Medical Society Luncheon

The Women's Medical Society of the District of Columbia will hold a reception for their members during the Assembly. They will have as their guests the women physicians from the District of Columbia and Virginia who are attending the scientific meetings.

The reception will be held Monday, November 1, from 5 to 7 p.m., at the Shoreham Hotel.

Woman's Auxiliary Luncheon

The Woman's Auxiliary to the Medical Society of the District of Columbia and the Woman's Auxiliary to the Medical Society of Virginia will meet together for a luncheon at the Sheraton-Park Hotel, November 2, at 1:15 p.m. The presiding officers will be Mrs. Kalford W. Howard, President of the Virginia Auxiliary, and Mrs. Duane C. Richtmeyer, President of the D. C. Auxiliary.

Present for the occasion will be the two highest ranking officials of the national organizations, Mrs. George C. Turner, President of the Woman's Auxiliary to the American Medical Association, and Mrs. George Feldner, President of the Woman's Auxiliary to the Southern Medical Association.

A review of fall and winter fashions by Selma's of Connecticut Avenue will be a special feature.

Annual Dinner

The program planned for this year's Annual Dinner is different. There will be no speeches. In their place will be a variety show, "Skitsophrenia"—A Medical Mélange, featuring an all doctor-and-wife cast. There will be skits, stunts and music presented by exceptional talent. Come and enjoy yourself. You will be surprised and pleased.

See Registration, page 517, for details about ticket sales.

Parking Privileges

Managers of the Shoreham Hotel and the Sheraton-Park Hotel have agreed to give the physicians attending the Assembly exclusive rights to both hotel garages and parking lots during the meeting.

Special parking rates at these hotels will be:

Garage—$1.25 up to 24 hours
Parking Lot—50 cents up to 24 hours

Parking stickers will be sent to members of both Societies prior to the Assembly. Parking lot attendants have been instructed to honor the parking sticker, which should be pasted on the windshield. Physicians must display the sticker to be entitled to the parking privileges offered by both hotels.

REMEMBER: No cars will be allowed in the hotel garages or parking lots without a First Interstate Scientific Assembly sticker.

Registration

As in previous years, arrangements have been made to register members of the Medical Society of the District of Columbia prior to the opening of the ASSEMBLY at the Society's Executive Offices on Thursday and Friday, October 28 and 29, from 9 a.m. to 5 p.m.

For several years the Society has sponsored a luncheon that in itself was an incentive to early registration. *This year there will be no luncheon given by the Medical Society for its membership.* However, members who find it convenient to do so will save time if they come to the Society's offices on the above dates and avoid being detained at the Registration Section at the Shoreham.

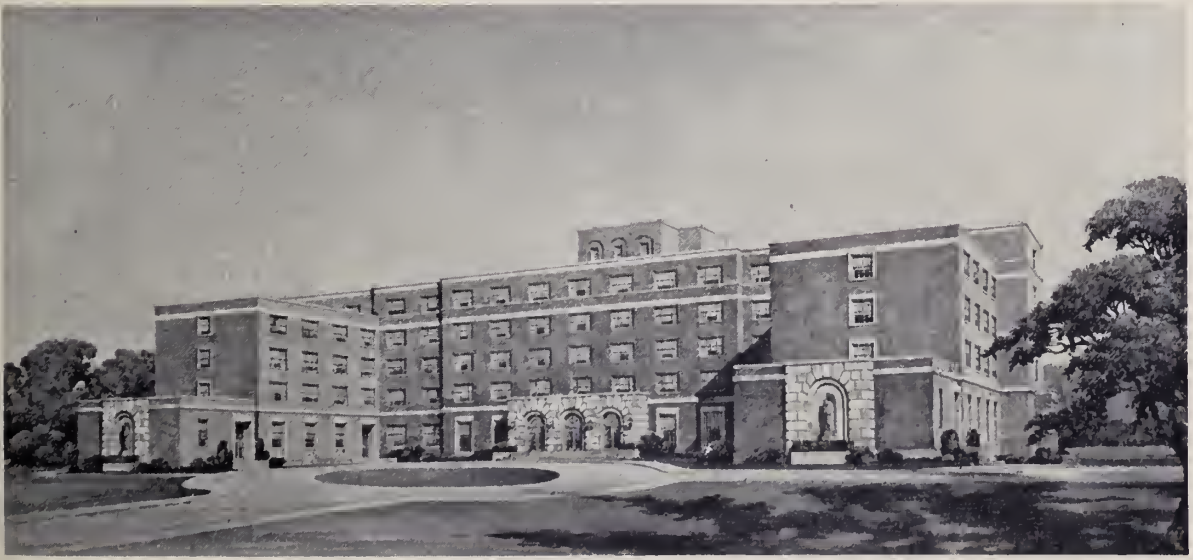
The Registration Section, which will be set up in the West Lobby of the Shoreham Hotel, will be open on Sunday from 2 to 5:00 p.m. and on Monday morning at 8 a.m. to permit everyone to register in time for the opening session.

The Registration Section will be divided into three departments: one for the registration of members of the Medical Society of the District of Columbia, guest physicians, interns, residents, exhibitors, etc.; one for the registration of Medical Society of Virginia members; and a central section to be devoted to the sale of tickets for the Annual Dinner and various luncheons and dinners sponsored by the alumni and specialty groups.

The usual procedure will be followed in the District of Columbia for the Annual Dinner, formal invitations being extended to physicians and their guests. For the convenience of those desiring to reserve tables, floor plans will be available at the Society's Executive Offices on the dates for preregistration, October 28 and 29.

Representatives of the Medical Society of Virginia have decided that their Society's usual procedure shall be followed with regard to the Annual Dinner ticket sales. Tickets will be made available to the Virginia House of Delegates and other physicians who register on Sunday afternoon and all day Monday in the Registration Section.

Tickets for the Annual Dinner will be $7.50 per person. The Dinner will be preceded by a cocktail party through the courtesy of Peoples Drug Stores.



New Shool of Nursing at Georgetown University Medical Center

Assembly Calendar

All Meetings at the Shoreham Hotel Unless Otherwise Indicated

SUNDAY, OCTOBER 31, 1954

9:30 a.m.	Potomac and Virginia Chapters, American College of Chest Physicians—Blue Room
12:30 p.m.	Potomac and Virginia Chapters, American College of Chest Physicians Luncheon—Blue Room; Round Table Discussion on "PULMONARY EMPHYSEMA"
12:30 p.m.	Potomac and Virginia Chapters, American College of Chest Physicians Luncheon—Louis Seize Room; Round Table Discussion on "EVALUATION OF PATIENTS FOR CARDIAC SURGERY"
1:00 p.m.	Council Meeting of The Medical Society of Virginia—Suite 100 C
2:00–5:00 p.m.	Registration—West Lobby
3:00–7:00 p.m.	Woman's Auxiliary Registration—Lower Main Lobby
7:00 p.m.	The Medical Society of Virginia House of Delegates, Dinner and Meeting—West Ballroom

MONDAY, NOVEMBER 1, 1954

8:00 a.m.	Registration—West Lobby
9:00 a.m.–Noon	Scientific Program—Terrace Banquet Room and West Ballroom
9:00 a.m.–Noon	Medical Motion Pictures—Foyer to Main Ballroom
10:00 a.m.–4:00 p.m.	Woman's Auxiliary Registration—Lower Main Lobby
10:00 a.m.	Medical Society of Virginia Reference Committee—Suite 100 B
10:00–11:00 a.m.	Mead Johnson Coffee Hour—Lower Main Lobby
12:15 p.m.	George Washington University Medical Society Luncheon—Blue Room
12:15 p.m.	Virginia Pediatric Society Luncheon—Suite 100 C
12:15 p.m.	Virginia Surgical Society Luncheon—Louis Seize Room
12:30 p.m.	Virginia Neuropsychiatric Society Luncheon—Adams Hamilton Room, Sheraton-Park Hotel
2:00–4:30 p.m.	Scientific Program—Terrace Banquet Room and West Ballroom
2:00–5:00 p.m.	Medical Motion Pictures—Foyer to Main Ballroom
2:00 p.m.	Virginia Woman's Auxiliary Preconvention Board Meeting—Suite 100 C
4:30–5:30 p.m.	Annual Meeting, Virginia Medical Service Association—Louis Seize Room
5:00–7:00 p.m.	Class of 1934, George Washington University Medical Alumni, 20th Anniversary Reception (suite to be announced)
5:00–7:00 p.m.	Women's Medical Society Reception (suite to be announced)
6:30 p.m.	Medical College of Virginia Reception—West Ballroom
6:30 p.m.	Tulane University Medical Alumni Reception and Dinner—Suite 100 C
6:30 p.m.	University of Virginia Medical Alumni Reception—Burgundy Room, Sheraton-Park Hotel
7:30 p.m.	Medical College of Virginia Dinner—Terrace Banquet Room
7:30 p.m.	University of Virginia Medical Alumni Dinner—Continental Room, Sheraton-Park Hotel

TUESDAY NOVEMBER 2, 1954

8:00 a.m.	Virginia Diabetic Association Breakfast and Business Meeting—Suite 100 C
8:30 a.m.	Registration—West Lobby
9:00 a.m.–Noon	Woman's Auxiliary Registration—Lower Main Lobby
9:00 a.m.–Noon	Scientific Program—Terrace Banquet Room and West Ballroom
9:00 a.m.–Noon	Medical Motion Pictures—Foyer to Main Ballroom

9:00 a.m.	Virginia Society for Pathology and Laboratory Medicine—Adams Hamilton Room, Sheraton-Park Hotel
9:15 a.m.	Virginia Woman's Auxiliary General Annual Meeting—Louis Seize Room
12:15 p.m.	Georgetown University Medical Alumni Luncheon—Blue Room
12:15 p.m.	Washington Orthopedic Club and Virginia Orthopedic Society Luncheon and Business Meeting—Suite 100 C
12:15 p.m.	Virginia Radiological Society Luncheon—Suite 100 B
12:30 p.m.	District of Columbia and Virginia Chapters of American Academy of General Practice Luncheon—Caribar Room, Sheraton-Park Hotel
12:30 p.m.	Virginia Obstetrical and Gynecological Society Luncheon—Franklin Room, Sheraton-Park Hotel
12:30 p.m.	District of Columbia and Virginia Societies of Anesthesiologists Luncheon—Madison Suite, Sheraton-Park Hotel
1:00 p.m.	Virginia Section of the American College of Physicians Luncheon—Louis Seize Room
1:15 p.m.	Joint Luncheon, Woman's Auxiliary to the Virginia and District of Columbia Medical Societies—Continental Room, Sheraton-Park Hotel
2:00–4:30 p.m.	Scientific Program—Terrace Banquet Room and West Ballroom
2:00–4:00 p.m.	Medical Motion Pictures—Foyer to Main Ballroom
4:00 p.m.	The Medical Society of Virginia House of Delegates Meeting—Louis Seize Room
6:30 p.m.	Cocktail Party (Courtesy of Peoples Drug Stores)—Lower Main Lobby
8:00 p.m.	Annual Banquet of The Medical Society of the District of Columbia and The Medical Society of Virginia—Blue Room and West Ballroom
9:30 p.m.	"Skitsophrenia"—A Medical Mélange—Terrace Banquet Room. A fast moving variety show presented by an all doctor-wife cast. The District of Columbia and Virginia are represented by exceptional talent.

WEDNESDAY NOVEMBER 3, 1954

8:30 a.m.	Registration—West Lobby
8:30 a.m.	Virginia Woman's Auxiliary Past Presidents Breakfast—Suite 100 B
9:00 a.m.–Noon	Scientific Program—Terrace Banquet Room
9:00 a.m.–Noon	Medical Motion Pictures—Foyer to Main Ballroom
9:30 a.m.	Virginia Woman's Auxiliary Postconvention Board Meeting—Suite 100 C
12:15 p.m.	Virginia Urological Society Luncheon—Louis Seize Room
2:00–4:30 p.m.	Scientific Program—Terrace Banquet Room
2:00–4:30 p.m.	Medical Motion Pictures—Foyer to Main Ballroom
7:00 p.m.	Dinner for the District of Columbia and Virginia Doctors' Office Staffs (Assistants, Secretaries, Nurses and Receptionists)—Terrace Banquet Room SPEAKER: **Leo E. Brown**, Director, Department of Public Relations, American Medical Association SUBJECT: "You Can Be a Star on Medicine's PR Team"
7:30 p.m.	(Reception 6:30 p.m.) Class of 1944, George Washington University Medical Alumni, 10th Anniversary Dinner—Kennedy Warren

The Technical Exhibit

Shoreham Hotel

MAIN BALLROOM, FOYER TO MAIN BALLROOM, AND BIRD CAGE WALK

Exhibitor	*Booth No.*
Abbott Laboratories	50
A. S. Aloe Company	15
Ames Company, Inc.	55
Arcum Pharmaceutical Corporation	64
Ayerst Laboratories	75
Baby Development Clinic	29
The Baker Laboratories, Inc.	51
Beech-Nut Packing Company	42
Benson & Hedges	18
Beth-Mont Surgical Supply Co.	62
Beuchler's	66
Bilhuber-Knoll Corp.	67
Borden's Prescription Products Division	10
Brayten Pharmaceutical Company	79
Burroughs Wellcome & Co. (U.S.A.) Inc.	68
Burton, Parsons and Company	14
S. H. Camp and Company	33
Carroll Dunham Smith Pharmacal Company	6
Ciba Pharmaceutical Products, Inc.	46
The Coca-Cola Company	80
Davies, Rose & Company, Limited	86
The Dietene Company	77
Doak Pharmacal Co., Inc.	81
Doho Chemical Corporation	3
The Dominion Laboratories	59
C. B. Fleet Co.	8
E-Fougera and Company, Inc.	54
General Electric Company, X-Ray Department	41
The Gibson Company	85
The Harrower Laboratory, Inc.	32
Charles C. Haskell & Co., Inc.	47
Hoffmann-La Roche, Inc.	84
Holland-Rantos Company, Inc.	31
Ives-Cameron Company, Inc.	57
Keleket X-Ray Corporation	88 and 89
Kloman Instrument Company, Inc.	17 and 17A
Lederle Laboratories Division, American Cyanamid Company	27
The Liebel-Flarsheim Company	73
Eli Lilly and Company	12
J. B. Lippincott Company	9
P. Lorillard Company	38
M & R Laboratories	44

Exhibitor	*Booth No.*
The S. E. Massengill Company	76
Maxwell & Tennyson Pharmacists	71
McKenna Surgical Supply, Inc.	25
Mead Johnson & Company	69
Medical Service of the District of Columbia and Virginia Medical Service Association	36
The Meredyth Company	58
The William S. Merrell Company	30
Miles Reproducer Company, Inc.	34
The National Drug Company	63
Ortho Pharmaceutical Corporation	83
Parke, Davis & Company	70
The E. L. Patch Company	78
Peoples Drug Stores, Inc.	13
Pet Milk Company	53
Charles Pfizer & Company, Inc.	26
Pharmacists' Surgical Supply Corp., Division of District Wholesale Drug	37
Powers & Anderson, Inc.	87
Wm. P. Poythress & Co., Inc.	82
The Purdue Frederick Company	14A
R. J. Reynolds Tobacco Company	60
A. H. Robins Company, Inc.	74
J. B. Roerig and Company	16
Sanborn Company	65
Sandoz Pharmaceuticals, Division of Sandoz Chemical Works, Inc.	56
W. B. Saunders Company	45
Schering Corporation	29
Julius Schmid, Inc.	35
G. D. Searle & Co.	61
Serviss X-Ray Company	49
Smith, Kline & French Laboratories	39
The Stuart Company	4
Swift & Company	43
U. S. Vitamin Corporation	2
Universal Products Corporation	12A
Vanpelt & Brown, Inc.	40
Walker Laboratories, Inc.	11
Warner-Chilcott Laboratories	72
White Laboratories, Inc.	48
The Williams & Wilkins Company	52
Winthrop-Stearns, Inc.	5
Wyeth Laboratories	1
Zimmer Manufacturing Company	7

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Ira L. Hancock, Jr. (Va.)

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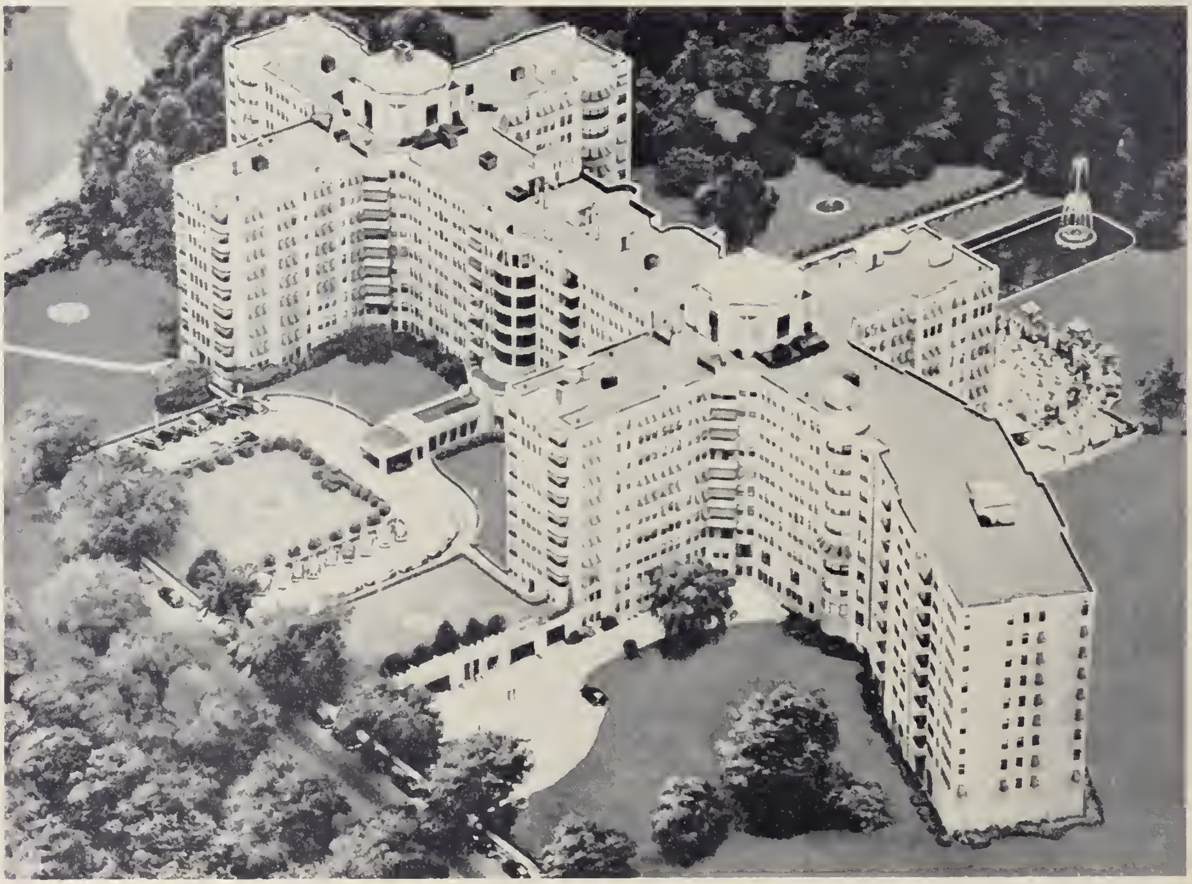

Aerial View of the Shoreham Hotel

President's Page

IN THE PUBLIC INTEREST

Many members of our Society are frequently troubled by unfavorable publicity of individual physicians or of medical organizations, including our own. It is important that each of us keep a proper perspective of such criticism clearly in view.

The action of no individual or group can always meet with public approval. There are honest differences of opinion, and judgment is not infallible. What is important, and what counts most, is what motivated the action provoking criticism. If judgment was honestly weighed and action taken in the public interest, there is no need for concern. Honest leadership will always demand its penalty of criticism.

Repeated public critical comments do have adverse effects. They can be disconcerting, but final judgment, based on fair appraisal, will cancel unjust censure. Such an outcome depends on whether an individual or an organization has kept faith with people. I am sure this has not always been true, but lapses have fortunately been fewer than the public has been led to believe.

A goodly number of our colleagues think that a more frank approach can be made to the public, leaving no doubts as to our sincerity and primary concern for the welfare of our patients.

Preston A. McLendon

Editorials

THE ERA OF ANTICIPATORY MEDICINE*

History reveals many great eras of medicine—the anatomic era of Leonardo da Vinci, the physiologic era of Harvey, the microbiologic era of Pasteur, the antiseptic era of Lister, the pathologic era of Virchow and Welch, the diagnostic era of Barker, Peabody and Hammon, and the recent therapeutic era of Halsted, Domagk and Fleming. The development of each new era has been made possible by the composite knowledge gained through previous and current medical research. Your challenge will be based on the next great medical era, which I believe will be the era of preventive or anticipatory medicine.

In this new period one can visualize the return of the important role of the physician as an individual, and the reëstablishment of the most valuable of all influences for security, the physician-patient relationship. The *Reader's Digest* and similar publications will no longer dictate medical policy through half-truths. Great dangers and tragedies such as the widespread sensitization of the population with penicillin will not occur. The indiscriminate use of penicillin by public demand for treatment of every minor infection will be unheard of. Investigators will be required by the editors of all medical journals to present 3- to 5-year follow-up studies of the effect of each new wonder drug before publication. Had this plan been followed in our day the great tragic failure of cortisone, the most highly publicized drug in history, would not have occurred. The hopes of millions of arthritics would not have been crushed, and a 5 per cent mortality from the effects of this drug would have been avoided. These inevitable failures with the use of new drugs on diseases where the underlying mechanism is still unknown will be preventable in the future.

You will know during your medical careers for the first time in the 1500-year history of struggle against disease the true nature and the basic mechanisms that you are treating in the host of medical ills which threaten the security of man. The present tendency to accept influences on diseases as causative, such as stress in hypertension, peptic ulcer, asthma and arthritis, will seem archaic in your new era. Cancer, in my opinion, will most certainly be preventable, not because of improvements in early diagnosis but because of an understanding of how the cell becomes malignant. In your time you will be amazed at our present satisfaction with the methods of treating coronary artery occlusion, for you will be able to reverse the relentless trend of arteriosclerosis itself. For those working on the frontiers of basic medical research the indications for the fulfillment of these predictions are already at hand, and far more tenable than the previous unlikely achievement of splitting the atom or a contemplated trip to the moon.

The present criticism leveled against medicine of today will not be evident in the era of anticipatory medicine. We are told that the general practitioner whom we all loved and needed must be brought back. Others say that we need an entire medical team of specialists to obtain medical security. Some think the large clinic with its great scientific tools for diagnosis is the only solution. In the midst of this there is no accounting for the cost which the sick individual with a catastrophic disease can ill afford. In the new era I visualize two kinds of doctors who will carry the major load. They will be sufficiently wise and well-trained to call on the team approach when necessary, but this need will be the exception rather than the rule. No one man will try to take care of all of our needs, and the public will learn to respect two major categories of doctors, operating doctors and nonoperating doctors. The nonoperating doctor known today as the internist will be the family physician of the future. His hospital and postgraduate training will be sufficiently extensive to place him in the position of being a specialist in all fields of internal medicine. In most instances there will be no need to send the patient to innumerable specialists and thereby lose the physician-patient relationship, to say nothing of the cost. The development of a new type of general surgeon will parallel the changes already occurring in medicine. His knowledge of physiology will be as significant to his patients as his technical skill. A sufficient number of community hospitals will be made available throughout the land which will provide the tools and thereby attract at least one general physician or internist and one general surgeon in all communities now lacking adequate professional care.

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* Adapted from an address delivered at the Precommencement Exercises for the Class of 1954 of George Washington University School of Medicine in Washington, D. C., June 8, 1954.

We have attempted to prepare you for your challenge by giving you an exposure and an emphasis on fundamental mechanisms of disease. With this background you can continue to grow and develop and meet any future change with confidence and security. With this training you will always know that there is no intermediate ground. Medicine is either good or bad. When human life is at stake it is not good enough to be half right. Your postgraduate education will teach you critique and how to avoid wasting your valuable time on worthless facts and ideas. You will attend conferences, clinics and meetings, continuing to study and advance with each new change in medicine. You will recognize that the art of medicine is an integral part of the science and not separated from it, for without the art a baseline for evaluation could not be established. You will find that the art without the science is equally ineffective. Personal charm and magnetism alone are not enough.

From the foregoing you can readily see why your future challenge is not only exciting but vital. The fear that the individual physician is being displaced by the group could only be entertained if you fail to receive the postgraduate training necessary for security. The ever-present fear of socialized medicine which would endanger the patient more than the doctor need not be as great a threat. It is less likely when the individual physician or surgeon are both broadly and deeply oriented to medical problems. The new era of anticipatory medicine will give new strength and vigor to the individual phyician who alone must decide the course his patient should take. The physician will have the basic knowledge to anticipate the very beginning of chronic illness and thereby prevent the threat of disability from uncontrolled chronic disease with exacting methods and tools.

I believe yours is a bright and happy future and one in which truth will prevail. The achievement of basic truth leaves no room for dissension or poor human behavior of the type so commonplace today. Your challenge, if based on the search for fundamental truth, can be met. It is my parting wish that your life be filled with good humor, lasting friendships, and great success.

THOMAS MCP. BROWN, M.D.
Professor of Medicine,
George Washington University
School of Medicine

ATTENTION WASHINGTON PHYSICIANS

The Clinical Center of the National Institutes of Health announces that a special study is now being conducted on the anti-inflammatory effects of certain promising agents in acute carditis. Physicians in the Washington, D.C. area are invited to refer early cases of rheumatic fever at any age with unquestionable, acute involvement of the heart for treatment and study. Referrals of cases of disseminated lupus erythematosus in acute fulminating phase or those who are not responding satisfactorily to cortisone, hydrocortisone, or corticotropin also are invited. Please communicate with Dr. Joseph J. Bunim, Clinical Director, National Institute of Arthritis and Metabolic Diseases, Bethesda, Md.

SHOULD MEDICAL SCHOOLS TEACH STUDENTS TO WRITE ENGLISH?

In a most discerning article* on the value of correlating the teaching of writing with instruction in non-English courses, Dr. Marvin J. Barloon, Professor of Economics, Western Reserve University, sets forth a unique method whereby he is teaching students in economics how to write what they mean. The method he describes is logical, practical, and simple. "The principles are so obvious," he says, "that it embarrasses me to recall that it took four semesters to get the process in order." The method has, for him, become some 90 per cent effective, which is about what he had hoped for. I believe such a score would gratify the most demanding professor, especially an English professor.

These comments are directed primarily toward medical school teachers, but lest they assume that by adopting Dr. Barloon's technic they will produce classes of physician-writers, may I caution that the technic has its limitations: It requires a good deal of student guidance and might entail too much work for classes exceeding 25, and "it can be used only by professors who themselves know how to write clearly"; but, the author graciously adds, the technic can be appropriated with no royalties charged.

Dr. Barloon developed his method in industrial economics, and justifies his teaching of English in his classes because "English is the stuff of which the subject is made," and, "In acquiring the skill of writing what he means, the student learns what he means." While Dr. Barloon does feel that mathematics and the natural sciences do not lend themselves as well to his teaching of English composition along with economics as do, for instance, history, philosophy, law, and some others, I am convinced that his method could very well be adapted to medical courses. Today more and more physicians are expected to be able to lecture before lay audiences, to speak on radio and television programs, and to become in turn teachers of medical students. Both medical and lay journals are constantly seeking new and interesting material from doctors. Research physicians are expected to describe accurately their observations and thus add the results of their findings to the literature. Groundwork for expression of fact and theory in a lucid and interesting style is well within the province of medical school teaching.

Dr. Barloon's teaching process has four elements or principles. They are:

"1. Teach the elements of a performance individually before teaching the whole performance.

"2. Show the student what you are trying to teach him to do before expecting him to do it.

"3. When a student does something wrong, show him precisely what he did wrong, and make sure he understands the criticism before asking him to correct it.

"4. A student has not learned how to do something until he has done it by himself without interference or guidance from the instructor."

Briefly, this is how Dr. Barloon proceeds to carry out these principles: He begins with the single paragraph, assuming that most students are able to write a satisfactory sentence. He hands each student a mimeographed sheet containing a group of sentences taken from a student's paper in an earlier semester. As submitted, the sentences constitute a scrambled paragraph. With the assistance of the students, the message of the group of sentences is written on the board in a single sentence; also, by questioning, he obtains the sequence of qualifying sentence, factual evidence, and logic, concluding with a restatement of the total message as a clearly organized paragraph. Ten minutes should suffice, he says, to make clear what a paragraph is.

The real work begins with requesting the students in the class to write a single paragraph on an assigned subject. "The subject should be so worded that it cannot be misunderstood and can be properly dealt with in a single paragraph." He makes sure that the students have access to readings which will provide them with the necessary information to form a supportable judgment. A suggested subject for a medical class might be: "One important public health problem in heart disease." Each paragraph submitted should be organizationally perfect, on the model displayed in class. Dr. Barloon's technic is based on the theory that there be no deviation from his (or the instructor's) method: ". . . we cannot teach the student how to vary his organization until he has an organization to vary; . . . he has to learn the elements of organization before he learns how to toy with those elements."

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* Barloon, M. J.: Am. Assn. Univ. Prof. Bull., 39, no. 2; reprinted in J. M. Educ., 1954, 29, 30.

The second assignment should relate to the first. A suggested topic might be: "One important public health problem in heart disease: the initial step in its solution." Again, organizational perfection is the objective, this time without rewriting. "A bare majority of the students may make it." For the remainder of the class an additional assignment is made, and, the professor says, "Those who don't make it on this try either don't want to or else need to be referred to a remedial writing class."

The third class assignment is a multi-paragraph paper, which is to include the two perfect paragraphs already written. A suitable topic might be: "One important public health problem in heart disease: the physician leads in community education." The paper must begin with a paragraph, perfectly organized, giving the over-all message, and must end with a similar concluding paragraph. Usually, he says, only a minority have to rewrite this job.

By choosing topics for assignment which relate to the subject currently under study, Dr. Barloon has found that "each student has been compelled to create his points for himself and then to choose each word and meticulously to rearrange every idea towards a precision of relationships" so that the result is a "precision of economic [but just as well, medical] ideas."

Dr. Barloon does not believe a term paper should be read at all which is not interesting. He calls for term papers early enough to allow for rewriting if necessary. When he comes to confused and disorganized work, he draws a red line across the page and writes in the margin: "Not read beyond here," and returns the paper for rewriting. "Nothing need be read which is not clear. And, if it is clear, you will find it interesting, that is, if you are as interested in your field as I am in economics."

The high school and college English composition courses are doing a reasonably good job, Dr. Barloon concedes, but students are inclined to think of English as a separate subject with no relationship to other verbal fields. The former courses provide the student with the tools he is to use and the latter should help him keep those tools in working order. "There's no jurisdictional dispute involved."

Dr. Barloon is under no illusion that his method will be widely acclaimed among educators. The inability of students to write is a universal complaint and one that will continue much as though his article had never been written. But it may interest a small minority who are tired of complaining and really want to see student writing improved. For that small minority the original article is well worth reading in its entirety.

A. L. E.

TEACHING US MORE

Through the general and specialized medical libraries now situated around the country, the doctor of today, for the price of a 2¢ postcard, can keep well up-to-date on any facet of his profession as compared to his counterpart of a half century ago, who valiantly fought to save his patients but had inadequate reference facilities at his disposal.

One such library of the many that exist is maintained by the American Cancer Society at its national office in New York City. For the time it takes to write them a note, a copy of the latest monograph or paper on a specified problem of cancer can be in the physician's or dentist's hands by return mail.

The services of this medical library are varied and diversified, but quite complete to the doctor desiring to know more about cancer. The original concept for the American Cancer Society's medical library was developed in 1947 by Dr. Charles S. Cameron, Medical and Scientific Director. From its inception as "a library which will act as a clearing house for 'all information' on what is going on in all corners of the neoplastic disease field," it has developed into a medical arsenal with the following services.

Information service. The library will provide any information requested relative to publications about cancer and methods of obtaining material. It is also prepared to answer questions concerning specific articles, books and authors in the cancer field.

Bibliographic service. The main purpose of the library is its bibliographic service, which is available to investigators, medical libraries and physicians. The more specific a bibliographic request can be, the more quickly a response can be prepared. In some cases, requests for bibliographies for bulk shipment to meetings can be fulfilled.

Package Lending Library. This library, modeled on the one at the American College of Surgeons, maintains a classified reprint collection from which pertinent reprints on specific topics are loaned to interested persons for specified periods.

Book collection. The library maintains a comprehensive collection of books about cancer and grants loans of these books on an individual basis.

Publications. Cancer Current Literature, An Index to Neoplastic Diseases is published monthly. To help meet heavy production and mailing costs, a token charge of $1.80 yearly is made for this publication. Subscriptions for this particular monthly should be addressed to Comptroller, American Cancer Society, Inc., 47 Beaver Street, New York 4, N. Y.

Another publication of the Society is the bimonthly *CA, A Bulletin of Cancer Progress.* It is digest size and is planned to assist the busy doctor in keeping up with the newest developments in cancer. This particular magazine is contributed free to any physician in Washington by the District of Columbia Division of the American Cancer Society as part of its professional educational program. All that is needed is a request to the Society's office at 1415 Eye Street, N.W., telephone Executive 3-3690.

Reprint volumes. Each year the library prepares in a bound volume the collected reprints of papers authorized by the recipients of grants-in-aid from the American Cancer Society and Committee on Growth. These are distributed without charge to a number of libraries throughout the United States on a geographical basis.

It is well that professional people be aware of these facilities that are so accessible. For any further information concerning this medical library on cancer, write either to the Medical Librarian, American Cancer Society, 47 Beaver Street, New York 4, N. Y.; or Cancer, Washington 5, D. C. Truly there are forces at work—TEACHING US MORE.

RAYMOND T. HOLDEN, M.D.
Chairman, Medical Committee,
District of Columbia Division of
American Cancer Society

In and Out of Focus

BY THE OBSERVER

"I Made Two Promises . . ."

Despite President Eisenhower's insistence on the passage of his health reinsurance bill, it went down to a thumping defeat. On July 13, the House of Representatives, by a vote of 238 to 134, sent the legislation back to committee, which, in effect, killed it for this session of Congress.

Angered by the rejection of what had apparently been aptly labeled his number one health bill, the President minced no words in a press conference which followed the House's action.

> "In the campaign I made two promises that have to do with the health of the American people," he said. "I said, first, that I was opposed to socialized medicine, and would use every single attribute and influence of the Presidential office to defeat any move toward socialized medicine.
>
> "I also said, in talking about the great deficiencies in medical care in this country, and, particularly, for people who can't afford the expensive type of service that is now available to us in our best hospitals, that something must be done. . . .
>
> "I am sure that the people that voted against this bill just don't understand what are the facts of American life.
>
> "I don't consider that anyone lost yesterday except the American people. . . . When the opponents of the plan get up in the House and say that this is only an effort of the Republicans to redeem our campaign promise, I plead guilty.
>
> "Of course, I am trying to redeem my campaign promises, and I will never cease trying. This is only a temporary defeat. This thing will be carried forward as long as I am in this office."

Although a description of this plan was set forth in this column in the April issue of the MEDICAL ANNALS, it is repeated here to refresh the reader's mind. Essentials of the proposed program were as follows:

> "Private insurance companies, voluntary nonprofit organizations, such as Blue Cross and Blue Shield, and other voluntary groups would be eligible to participate (in the reinsurance program) if they complied with requirements, and if they were approved by the Secretary of Health, Education and Welfare.
>
> "The Secretary would determine the conditions under which insurance plans could participate, taking into consideration their objectives, including the extension of coverage to persons not now protected, the extension to new geographic areas, and the provision of benefits and services not now readily available.
>
> "Plans would not be approved unless they were (a) financially sound, (b) operating in accordance with state laws, and (c) deemed worthy of public confidence.
>
> "The Secretary would determine minimum benefits and waiting periods and establish safeguards against undue exclusions such as preëxisting conditions or specific illnesses.
>
> "Plans of given kind or type could be reinsured only if reinsurance on comparable terms and conditions is not available from private sources.
>
> "The Secretary would maintain a technical, advisory and information service to assist health insurance plans without cost. This service would also conduct studies and collect and distribute information on the organizational, actuarial, and other problems of health insurance.
>
> "Reinsurance plans would be protected against abnormal losses up to 75 per cent."

The reaction of Washington newspapers to the House's action was decidedly pro-Eisenhower. Even the conservative *Washington Evening Star* had this to say:

> "Recommittal of the administration's health reinsurance bill in the House may be considered a political setback for President Eisenhower. Taken out of the political context, however, the House action—as the President told his news conference—is much more a defeat to the interests of the American people."

As expected, the *Washington Post* was critical of the opponents of the legislation:

> "President Eisenhower is right in saying that the defeat of his health reinsurance bill by the House of Representatives is a critical loss for the American people. The House has turned its back upon the most hopeful middle-

> of-the-way measure that had been devised to bring health protection within the reach of many families.
>
> "It appears that the measure was caught in an unfortunate cross-fire from ultraconservative Republicans who feared that it might be a first step toward socialized medicine and Democrats who favor a compulsory health-insurance system."

The independent *Washington Daily News* said:

> "The American Medical Association disapproved of this bill. Apparently that carried some weight in Congress. But the AMA's attitude should not determine the issue, because it would not affect physicians except to enable more of their patients to pay their bills.
>
> "If doctors prefer that the number of charity patients not be reduced, they have the right to say so, but prospective patients—who outnumber doctors considerably—should be heard as well.
>
> "Aside from the AMA's role, it appears that the bill lost because, as Republican Leader Halleck said, it was too conservative for many House liberals and too liberal for many conservatives. And then, of course, there was much of the usual election-year politicking.
>
> "The national problems that fathered the reinsurance bill still exist.
>
> "They must be solved.
>
> "That's why the Administration should keep plugging."

Columnists, radio and TV commentators, of course, also had their say. Generally, their views were favorable to the President. Some of them were severely critical of the American Medical Association.

Widespread criticism undoubtedly prompted the AMA to release a statement directed to newspaper editorial writers, in which it was stated:

> "While it is true that the AMA opposed the measure from the very beginning, the Association was not alone in the ranks of the opposition. Most of the Nation's insurance experts have also opposed it. After weeks of meetings, discussion and study, this opposing group came to one salient conclusion: The bill, as considered by Congress, would add nothing to the present rapidly expanding and successful health insurance field."

Listed were six principal reasons why the Association opposed the bill:

> "1. The mechanism suggested will not accomplish the stated purposes of the bill: to promote the best possible medical care on reasonable terms.
>
> "2. The phenomenal progress of the health insurance industry makes Federal intervention not only unnecessary but a dangerous intrusion into a successful area of private enterprise. Such intervention would not help and could hinder continued expansion of health insurance coverage.
>
> "3. 'Reinsurance' would not make health insurance more attractive to persons who can afford to pay premiums and have not done so. It would not make health insurance available to the indigent unless the Government provides a subsidy for the purpose of selling insurance for less than the cost of servicing the contract.
>
> "4. The program, without subsidy, would not reduce the cost of insurance, nor would it make health insurance available to any additional groups or geographic area that voluntary insurers cannot reach.
>
> "5. Most insurance authorities agree that the extent of health insurance liability is such that a Federal reinsurance program is absolutely unnecessary.
>
> "6. The measure would place extensive regulatory power in the Secretary of Health, Education and Welfare. The concentration and delegation of such authority and control over a vital branch of American industry in an Executive Department of the Government without clear and convincing evidence of need cannot be justified."

There are a number of physicians who have had misgivings about the AMA's attitude toward the health reinsurance proposal. Not that they favor socialized medicine or more government in medicine, but they are disturbed by the frequency with which the Association feels itself obligated to take a negative position. They wonder if a serious attempt was made to find a common ground.

Since the advent of the new Administration, they point out, the political climate where organized medicine is concerned has been more favorable than in several decades. Due to the recent differences there is concern lest the President and the AMA have come to the parting of the ways. This would not bode well, in their opinion, for the people or the medical profession.

A less rigid and more coöperative attitude on the part of both the AMA and the Administration, they argue, is needed.

"This . . . Is Heresy"

One of the most widely discussed subjects in medical circles is the financial plight of our medical schools. While there are diverse opinions as to the remedy, deficit financing, it is generally agreed, cannot go on indefinitely. Eventually something will have to be done to bring about their solvency.

As is well known, tuition charges fall far short of footing the bill. Schools have therefore had to rely on outside sources to pay their bills. State-operated institutions fall back on Government subsidy while private schools seek and often obtain substantial gifts, endowments, and, to an increasing extent, Government grants.

Obviously, the private school is most vulnerable to financial difficulties, consequently their repeated appeals to alumni, persons of wealth, charitable foundations, and fund-raising organizations. Among the latter is the AMA-sponsored American Medical Education Foundation, which came into existence in 1950. Largely through its efforts, an ever-increasing number of physicians are making more or less sizable contributions to medical schools.

In establishing the Foundation, the AMA, prompted by its well known aversion to Government control of medical schools, donated a half million dollars, which was followed by other substantial contributions. At first physicians were somewhat lethargic in following this lead, but as time passes there is tangible evidence that doctors intend to do their share toward maintaining our medical schools independent of the Federal Government.

Whether this and similar efforts will obviate the necessity for Government subsidies remains to be seen. If these efforts should fail, there would seem to be no alternative. However, medical leaders in the forefront of the campaign to obtain voluntary contributions insist that this need not happen and they propose to see that it doesn't.

Dr. Brian Bird, Assistant Professor of Psychiatry in the Department of Psychiatry, Western Reserve University School of Medicine, sees this situation quite differently from the majority of his fellow physicians. He is one of those who questions the propriety of any of the present methods of raising funds.

In an article entitled "The Financing of Medical Schools," which appeared in the June 1954 issue of *The Journal of Medical Education*, he asked these questions of his readers: Is it absolutely essential to get outside support? Is it even wise to seek outside support? Is it a tried and true fact that tuition cannot pay the whole amount of medical school costs? Is it not possible that medical education would gain immeasurably if costs were met internally?

He then states his thesis:

> "Doctors, the finished product, are not poverty-stricken. They are, rather, among the higher income groups, the good earners in any community. Looking at their financial standing, it is ridiculous to consider that they should receive public support. Yet they all have received such support. Every doctor has had something for nothing, and a good lot of that something too. Speaking in terms of money—and that should be no disgrace—the doctor has received free, without any incumbrance, many thousands of dollars, which in turn enable him to earn, honestly, respectably and rightfully many thousands of dollars a year for life.
>
> "This does not mean that doctors make too much. They do not. If anything, they should earn more—not less. A high level of medical practice is an extremely skilled and responsible occupation and should bring a very high financial return.
>
> "But the point in question is not that doctors make a lot of money. What is in question, what is paradoxical, is this: Isn't it odd that they should not themselves pay in full for the education which makes it possible for them to earn so much?
>
> "In view of the fact that the practice of medicine is not altogether a charitable, self-denying calling—that, as well, it is a money-making occupation—it is difficult to understand an appeal to the public or to the state for the education of people who, as a result of that education, will be provided for so comfortably. Not only is it difficult to understand, it seems wrong. Doctors are well able to pay in full for their own education and without doubt should do so."

Anticipating criticism of such views, Dr. Bird continues:

> "This, of course, is heresy—or at least so it will seem to many. To broach openly the fact that doctors profit from illness, to suggest openly that doctors should pay for their own education in a businesslike way, to do anything of this kind will be interpreted as an unwarranted attack upon the role of the doctor as a Good Samaritan. Such a reaction is to be expected. It is only hoped that such feelings will not completely cloud the issue. The doctor's role as a healer, a helper, a man of good will, must be preserved and can be preserved without cloaking him in a disguise."

Among other arguments advanced by Dr. Bird for his proposal are:

1. Admitting that the doctor's earning capacity begins only after his education, or the expensive part of it, is over, he sees no reason why the student should not obligate himself in the amount of $2,000.00 per year for his schooling, to be paid off in 10 to 15 years after graduation. Dr. Bird does not believe that this would in the least affect the enrollment in medical schools and it would be good for the future of the physician from the standpoint of self-respect.

2. He insists that if medical schools are to continue to be free, they cannot accept a subsidy from any outside source, especially from the Government. He says that: "The increasing extent to which medical education is a charitable enterprise and the decreasing extent to which students pay for their own education will lead inevitably to a cry for salaried physicians paid by the state and paid less and less." In other words, carried to its ultimate conclusion, it will lead to the elimination of private medicine.

Then, too, he observes: "The medical student who has had dinned into his ears, year after year, the wail of the educators that he does not meet the bills for his education, develops such a feeling of guilt that he cannot as a doctor stand up to fight for his freedom."

3. It may be, he concedes, that some doctors cannot afford to pay the cost of their education. He is confident that this is not true of "the average practicing physician." The situation of those engaged in teaching and research is a different matter. Their incomes are comparatively small. This could be solved if tuition were raised to full cost and these physicians adequately paid.

Finally, Dr. Bird admits, perhaps fortunately for him, that there are undoubtedly many other arguments, pro and con, and that "all should be voiced and heard." But he still insists that doctors should pay for their own education.

★

"Not Another Suitcase?" The other day a physician was heard to comment on the presents doctors give each other as tokens of appreciation for services rendered them and their families. He offered to wager that in most doctors' homes there was a surplus of suitcases, for he said that was the most popular gift of all. He had garnered quite a collection himself, he admitted. Briefcases, he observed, would run a close second and, best of all, there was fruit—in and out of season.

Perhaps it would be wise to interject here that while some of this physician's observations provoked much amusement, he had a serious purpose in mind in discussing the matter. "Most doctors," he said, "gladly comply with Principles of Medical Ethics in which it states, 'A physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity'; but many have felt that gratitude should be shown in a tangible manner. If this were done physicians would be less reluctant to call upon their fellow practitioners when they and their families are in need of their services!"

Interestingly, the *Detroit Medical News* for June 14, 1954, editorializes in much the same vein:

> "One reason doctors are inclined to neglect their health and that of their families is because of misunderstanding about professional courtesy. Many physicians are reluctant to impose upon the time of a colleague for a periodic health inventory. They are almost as reluctant to seek help when they are acutely ill. They feel that the occasional referral of a paying patient or the presentation of some useless gift is inadequate compensation.

They would rather pay as other patients do for professional services rendered.

"The case against charging physicians and their dependents professional fees is not easily stated. It is emotionally charged. It involves spiritual values. The tradition of professional courtesy is more ancient than written medical history. It existed before the days of Hippocrates. It has distinguished practitioners-of-medicine from members of other professions for thousands of years. When the medical student obtaining treatment asks for his bill, and the older physician places an arm across the young doctor's shoulders and says, 'You owe me nothing, lad. Doctors don't charge other doctors,' that student catches a vision of brotherhood, of greatness, and of nobility he will never forget. It may be an unreasonable tradition, but it is a magnificent one. It should not be lost in this competitive, materialistic age.

"The case for charging physicians and their dependents is more simply stated. Physicians would be less reluctant to seek medical care if they paid for professional services.

"Doctors reluctant to seek medical care from their colleagues should review the ancient writings of Hippocrates. They should reflect on the origin and significance of one of our distinguishing traditions: professional courtesy. It is an honor and a privilege to care for a fellow physician. And Medicine as in ancient days is still a noble brotherhood. If some still feel that the doctor's doctor should be more adequately compensated, we might consider the advisability of securing group insurance for ourselves and our dependents designed to remove this objection.

"Would doctors and their families get better health care if our tradition of professional courtesy were abandoned?"

This undoubtedly represents the thinking of many doctors. From time to time it has been suggested that arrangements should be made for Active members of the Medical Society to subscribe as a group to their own Blue Shield Plan, Medical Service of the District of Columbia, as they now do to Group Hospitalization, Inc. However, others have rejected the proposal on the ground that it violates the spirit and traditions of the medical profession.

In view of recent and apparently widespread interest in this matter, this would appear to be the logical time to canvass Society members to ascertain their views.

Languid and Inelastic?

The death of Dr. Fred W. Rankin this past summer brought to mind the thought-provoking and dramatic President's Address he delivered before the AMA's House of Delegates on June 7, 1943.

Dr. Rankin, then on duty in the office of the Surgeon General of the Army in Washington, had high praise for the medical profession's contribution to the war effort. He said:

> "No other group has shouldered its responsibilities in this emergency with greater self abnegation, more cheerful enthusiasm, and more efficient adaptability.
>
> "That we have performed this function successfully is demonstrated by the fact that we have given our civilian workers production superiority in the rapidly expanding war-geared industries, and our armed forces combat superiority in the jungles of Guadalcanal, on the gale-swept North Atlantic, and on the blistering deserts of North Africa."

But this, he said, was not enough. Having completed medical mobilization for war, it was not too early to give consideration to the postwar period.

> "It must now be apparent, even to those who have been most purblindly recalcitrant," he said, "that mighty influences are at work to effect epochal changes in the complexion of medical practice. While it would appear that these influences have suddenly loomed on the medical scene, it should be realized that they have long been forming and that the present military conflict has merely hurried their development and magnified their significance. That they can no longer be ignored seems difficult to controvert. We must face realistically these tremendously forceful socioeconomic trends which are intimately involved and deeply concerned with the Nation's medical problems.
>
> "The directional sign posts of postwar planning may now be clearly read by proposals already made for broadening the social security program and extending the Nation's economic resources to assure 'adequate medical and health care for all, regardless of place of residence or income status.' The complex connotations and inevitable implications of these plans and proposals make it quite apparent that the old system of medical practice will be considerably modified.
>
> "If the limitless and baneful potentialities that can be projected into the science and art of the future of medicine are to be averted, it becomes imperative in this

> transition period that the wise and tempered counsel of the medical profession exert its proper influence. Have we so long basked in the luxuriating rays of medicine as the apotheosis of professions that we have become languid and inelastic in our attitude and hesitant and fearful in our response to existing socioeconomic developments? I sincerely hope not."

He then sounded the keynote of his address.

> "It is becoming increasingly apparent that the trends now gathering momentum are directed toward some form of national health service as an integral function of the state. Proposals of this nature by governmental postwar planning agencies, both here and abroad, have been the subject of deep consideration, wide editorial comment and cogent discussion. This mood has been further reflected in recent comments by various medical and nonmedical writers who have penetrated with incisive clarity to the very heart of this controversial subject.
>
> "It has been stated by some that the financing of this type of medical service is a socioeconomic consideration and not a medical problem. While it may be argued that financial provision for the institution of such a service is a function of the commonwealth, I am impelled to emphasize the fact that the structural character of the organization of any such type of health service is tremendously important to doctors and is vitally concerned with the execution of their professional function. This entire subject must be brought into sharp focus by the light of trenchant and dispassionate thought in order to observe both the desirable as well as the possible apprehensive aspects of the contemplated proposals."

As one reads Dr. Rankin's views a decade and a year later, one is impressed with his understanding of the problems lying ahead for medicine. Before his death, he must have taken deep satisfaction in the widespread acceptance by the medical profession of its responsibility for providing medical care at a cost which would be less burdensome to the patient.

Despite the phenomenal progress which has been made in the voluntary health insurance field, there are still challenges to be met. Medical prepayment plans are still too limited in their coverage. Comparatively few plans include medical benefits or afford protection against the costs of catastrophic illness. These are the immediate objectives to be attained and no doubt they will be in the foreseeable future.

While much credit is due those courageous and dedicated pioneers who have laid the foundations of prepaid medicine, the profession is equally indebted to such clear-thinking medical leaders as Dr. Rankin. His address was a far cry from the routine efforts which characterized most presidential addresses of that period.

★

Prestige Score Only infrequently is your Observer sufficiently interested to scan the financial pages of his newspaper. It was on such a rare occasion that he made acquaintance with J. A. Livingston's column, which appears regularly in the *Washington Post.* This one was entitled "Ach du Lieber Businessman, Your Prestige Is Overrated!"

The column was largely concerned with the disillusioning experience of Siegfried Weisberger, owner of the famous Peabody Bookshop in Baltimore, who, because of an indifferent buying public, was forced to dispose of his books, prints and etchings to Gimbel's, of New York. In his disappointment, Weisberger described this era as an "age of the boob, big business, technology, and the death of the humanities." "Americans," he said, "no longer respect the doctor, the lawyer, the professor. Today they all idolize—look up to—the businessman."

That observation prompted Mr. Livingston to comment on a survey made by the late Paul K. Hatt, Professor of Sociology at Northwestern University, to determine the prestige rating of persons engaged in various occupations.

> "Justices of the Supreme Court," Mr. Livingston reported, "took first place with a score of 96. (The President wasn't rated.) Next came physicians with a score of 93. They ranked on a par with state Governors and a point above members of the President's Cabinet.
>
> "Scientists, college professors and congressmen scored 89. Now comes the first businessman—a banker. He rates 88, a point higher than the minister. A member of a board of directors and a lawyer rate 86, and an artist 83, along with an airline pilot. Then comes the factory owner—business proprietor.

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GRIEVANCE COMMITTEE CASE REPORTS

Case Report 1

The following report is based on a complaint received recently by the Grievance Committee. While all the facts presented are true, they have been arranged in such a manner as not to embarrass anyone. The sole purpose of this report and those that follow is to call attention in as graphic a manner as possible to the typical complaints with which the Committee must deal. The Committee hopes that they will serve to promote a better understanding of the problems which arise between physicians and patients and how best to solve them, thus building up a better relationship between members of the medical profession and their patients.

Patient's complaint. In a communication addressed to the Committee Mr. B stated that on a Saturday morning in November, 1953 his son became quite ill and was "running a high temperature." He telephoned Dr. J for the purpose of asking him to make a call at his home. After several unsuccessful attempts to reach him, Mr. B called the Medical Bureau, which promised to notify Dr. J immediately.

No call having been received from Dr. J by Sunday, Mr. B again tried to reach him. Failing in this, he got in touch with Medical Bureau and again requested that the Bureau contact the physician. According to Mr. B, the Bureau operator said she remembered the call from the day before and that the doctor had been notified. However, she said she would call again at once.

Immediately thereafter Dr. J's receptionist phoned Mr. B stating that "the doctor would not make the call because the child was not his patient and because he did not take anyone as a patient from the other side of the tracks."

Mr. B inquired of the Committee whether it was ethical for a physician to limit his practice to defined boundaries. He stated that he lived one mile from the doctor's office and one block from the "tracks."

Physician's comment. Following the usual procedure, Dr. J came to the Society's office and read the patient's complaint. In his reply to Mr. B's charges Dr. J stated that Mr. B's children were not his patients, and that he had seen them on two occasions only for another physician. It was his understanding that at the present time they were under the care of Dr. Y, and Dr. J had been called because the parents were dissatisfied with the progress the children were making. Dr. J did not feel free to take care of the children without a call from Dr. Y.

In regard to his failure to answer the telephone message from Mr. B, Dr. J stated that he had endeavored to return Mr. B's call but had been unable to get a response; however, he said that he might have been dialing the wrong number. At any rate, he continued, if he had reached Mr. B he would have told him he could not make the call under the circumstances. As reported by Mr. B, Dr. J's receptionist reached him on Sunday with this message. No reference was made by Dr. J to Medical Bureau.

Dr. J maintained that he had the right to limit the geographic boundaries of his practice. He emphasized the size of his practice and that it was all he could do to handle what he had if he was to give good service. He said to him quality was far more important than quantity.

As to the statement about "the other side of the tracks," he was certain that it had never been made, because it would never have occurred to anyone in his office to say such a thing.

Patient's response. The Committee thought it desirable to send a copy of Dr. J's letter to Mr. B. Shortly thereafter, Mr. B wrote a letter in which he stated that he could not allow Dr. J's communication to go unanswered because it would "compound his wrong."

Mr. B challenged Dr. J's statement regarding Dr. Y taking over the care of his child. Dr. Y, Mr. B explained, was too far away from his home to make calls, and he had therefore asked him for the names of two physicians in his neighborhood, one of whom was Dr. J.

Mr. B did not believe Dr. J had repeatedly tried to reach him by telephone. If he dialed the wrong number he was inefficient if not negligent.

Mr. B was not impressed by the fact that Dr. J was reluctant to treat his children because other doctors had been in attendance. He felt that the choice of physician still resided with the patient.

As to geographical boundaries, Mr. B said that he did not challenge Dr. J's legal right to set them, but he thought it was contrary to the profession's code of ethics. He insisted that the receptionist was

DR. FREEMAN HONORED BY COLLEAGUES

There were many expressions of deep regret when it was learned that Dr. Walter Freeman, former President of the Medical Society of the District of Columbia, and one of Washington's most distinguished physicians, was leaving the city where he had practiced his profession for so many years.

Few of his contemporaries have been as internationally known for their contributions in their respective fields as has Dr. Freeman, and none has been more widely traveled. Speaking engagements have taken him to all parts of this country and Europe.

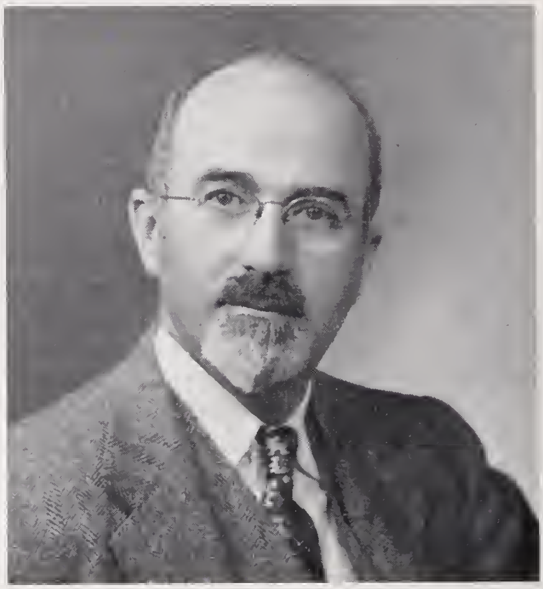
On May 22, 1954, 75 of his fellow-physicians honored him at a testimonial banquet at the Sheraton-Carlton Hotel in Washington. It was a happy but nostalgic occasion.

Dr. Zigmond Lebensohn was a most engaging toastmaster. Having at one time been associated with Dr. Freeman, he related many amusing incidents, as did the principal speaker, Dr. Temple Fay, Professor of Neurosurgery, Temple University, whose subject was "Philadelphia Days."

Following the conclusion of Dr. Fay's talk, Dr. James W. Watts, more recently associated with Dr. Freeman, presented him with a Polaroid camera. In his acknowledgment Dr. Freeman thanked his many friends for their kindnesses and said that their friendship would always mean a great deal to him.

The committee on arrangements for the banquet consisted of Drs. Paul Chodoff, Lebensohn, Watts, and Jonathan Williams.

Dr. Freeman left Washington with his family the middle of June for San Bernardino, California, where he will practice and make his home.



WALTER FREEMAN, M.D.

Aside from his scientific attainments, Dr. Freeman has long been prominent in the affairs of the Medical Society of the District of Columbia. As previously stated, he had been its President and served both as a member and Chairman of the Executive Board, and as a member of numerous committees. He was always deeply interested in all matters pertaining to the organization and his advice and guidance will be the District's loss but California's gain.

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not telling the truth if she denied making the reference to "the other side of the tracks."

Physician's testimony. Dr. J appeared before the Committee and reiterated that Mr. B's children were not his patients. He insisted that Mr. B was a "shopper," and had gone around to several physicians. He further stated that he received about 100 telephone calls during the day and 20 to 30 at night. He said Medical Bureau had called him, as reported, and the Bureau was not responsible for his failure to get in touch with Mr. B. He readily admitted that his receptionist had told Mr. B that he could not make the call because of the distance, and, furthermore, that he did not call on other physician's patients without being assured that the previous doctor had been discharged. He said that when he last saw the children for Dr. Y he had informed Mr. B that he could not attend them again except in an emergency.

On being questioned about setting boundaries, Dr. J repeated that he was so burdened now that he was forced to place a limit on the distance he traveled if he was to give proper care to his patients. He admitted that he should have called the Bureau when he did not reach Mr. B on Saturday, and said he was prepared to apologize for failing to do so.

Committee's conclusions. Members of the Commit-

(*Continued on page 548*)

On the Lighter Side

September 17, 1954, will usher in a brand new bowling season for the District of Columbia Medical Bowling League. Dr. J. W. Price, last year's Vice President, was unanimously elected President for 1954–55 at a recent meeting of the team captains. Dr. Gordon R. MacDonald, recently elected captain of the Georgetown team, was chosen to be the new Vice President of the League. Hi-Skor Bowling Alleys will be host to the League again this year, and the new starting time will be 9 p.m. Friday of each week. Physicians who wish to participate in this exciting sport may join the League by contacting the President, the Vice President, or the Secretary and official scorer, Mr. William B. Cochrane.

One of the most successful bowling seasons in the League's history was completed in May 1954. Competition was ferocious (of the cut-throat variety) but friendly. There were no individual or team scores taken for granted without the opposing team checking all figures, and sliding toes were not allowed over the foul line without howls of protest; but the ribbing was always jocose and the prizes at the end of the season were well worth all the scars of the battle.

Bowling League honors and prizes for 1953–54 went to the following physicians: Dr. Andrew J. Betz, high League average of 109–59; Dr. Gordon R. MacDonald 107–29; Dr. George A. Resta 107–18; Dr. Francis X. Richardson 107–12. High individual game of 170 was shared by Drs. John P. D'Angelo and J. Phelps Hand. Second high individual game of 154 was rolled by Dr. Millard Ottman. Dr. Richard J. McNulty bowled the highest individual set of 393, Dr. Ambrose H. Cook 389, and Dr. John W. Price 386. High strikes of 42 were claimed by Dr. James H. Roberts, and Dr. Maurice Van-Kinsbergen claimed second high with 41. High spares of 166 went to Dr. Charles Hageage and second high of 164 went to Dr. G. Roland Gable. Dr. John F. Finnegan was third with 160.

The individual bowlers who by their outstanding ability won prizes for the high team average are listed in the order of the team's final standing: Casualty—Dr. Alfred Dibbs 96–50; George Washington—Dr. Bernard A. Fitzgerald 103–73; Sibley #1—Dr. George L. Ball and Dr. John F. Finnegan tied with 106–1; Sibley #2—Dr. Willis B. Morse —102–82; Suburban—Dr. Robert B. Irey 101; Washington Hospital Center—Dr. John A. Kennedy 98–59; Columbia—Dr. J. Earl Kadan 102–75; Children's—Dr. Thomas J. Pekin 103–46; Prince Georges—Dr. Frederick E. Musser 105–26; Georgetown—Dr. Roy G. Klepser 105–56; Doctors—Dr. W. Robert Perkins 101–1; Garfield—Dr. William G. Cushard 104–20; Emergency #2—Dr. Harold H. Hawfield 101–42; Providence—Dr. Alan R. Crain 100–31; Good Hopers—Dr. Alfred Wilson 103–7; and Emergency #1—Dr. Robert R. Montgomery 97–76.

PROVIDENCE NOTE: The Fifth Annual Providence Hospital Alumni Association outing and banquet was held at the Kenwood Country Club on June 15, 1954, with Dr. Louis J. Goffredi presiding. Seventy-two physician members and their guests participated in the golf tourney and 208 persons were present for the banquet. The honored guests included Archbishop O'Boyle, Bishop McNamara, Dr. Herbert P. Ramsey, President of the District of Columbia Medical Society, Mr. Theodore Wiprud, Judges Thomas D. Quinn, of the Municipal Court of Appeals for the District of Columbia, and Matthew F. McGuire, of the United States District Court, and other prominent physicians and Washington businessmen.

Drs. Lou Gray and Frank Crilley tied for low gross with 74 and Dr. Vincent J. DiFrancesco won the low net trophy with a commendable 85–25.

Dr. Philip Caulfield was honored with a plaque inscribed "For Meritorious Service to the New Providence Hospital," and Dr. Richard J. McNulty received a plaque "For Thirty Years of Distinguished Service to Providence Hospital." Dr. H. H. Leffler, who served as pathologist to Providence Hospital for 14 years, was honored with a scroll and certificate. The "Bullthrower" trophy was awarded to Dr. Thomas F. Collins for you-know-what.

J. EARL KADAN, M.D.

News and Personals

MEETINGS—Past and Future

Continuing its plan of previous years, **the George Washington University School of Medicine** will offer a part-time **postgraduate course** beginning on October 7, 1954, and continuing for 16 sessions.

The course is entitled "Metabolic Diseases, Arthritis and Gastroenterology," and it is planned for physicians in practice in the Washington area. Sessions will be held in the George Washington University Hospital on Thursday evenings from 8:30 to 10:30 p.m. The topics to be considered are those occurring in a busy medical practice and the discussions will be at a practical level. Special emphasis will be placed upon the mechanism of diseases and principles of diagnosis and treatment. The basic sciences will be stressed when they can contribute to the understanding of clinical problems. There will be time each evening for questions and answers. Tuition for the course is $50.

The final schedule of the course will be distributed by mail in September to all physicians in the Washington area. Those interested in further details may call or write to Dr. Thomas M. Peery, Director of Postgraduate Instruction, George Washington University Hospital, Sterling 3-7800.

Physicians are invited to attend the **Annual Meeting of the American Roentgen Ray Society,** to be held at the Shoreham Hotel, September 19–21. On display will be numerous scientific and technical exhibits. Dr. Ralph M. Caulk is Chairman of the Committee on Local Arrangements.

The Eastern Section of the American Trudeau Society will hold a two-day meeting, October 22 and 23, at the Sheraton-Park Hotel. All physicians are invited to attend.

The Potomac and Virginia Chapters of the American College of Chest Physicians will hold a joint meeting at the Shoreham Hotel beginning at 9:30 a.m., Sunday, October 31, the day preceding the opening of the FIRST INTERSTATE SCIENTIFIC ASSEMBLY. All physicians are cordially invited to attend. There is no registration fee for guests or members.

Dr. Edgar W. Davis will be moderator for the Symposium on Cardiac Surgery which opens the scientific program at 10 a.m. Speakers will be Drs. Elton Watkins, Boston; Henry T. Bahnson, Baltimore; Charles A. Hufnagel, Washington; and Robert P. Glover, Philadelphia.

At 12:30 p.m. there will be two round table luncheons. Dr. James J. Feffer will be moderator for the one on Pulmonary Emphysema. Participants will be Drs. Bruce Armstrong, Baltimore; Milton Gusack and Paul Jaquet, Washington. For the second round table discussion, Evaluation of Patients for Cardiac Surgery, Dr. Bernard J. Walsh will be moderator. Discussion will be led by Dr. John O. Nestor, Washington, and Dr. Robert P. Glover, Philadelphia.

For the panel discussion, beginning at 2 p.m., on Problems Encountered in the Present-day Management of Tuberculosis, Dr. Sol Katz will be moderator. The panel will be composed of Drs. Moe Weiss, Glenn Dale, Md.; Edward S. Ray, Richmond, Va.; Donald R. Sickler, Washington; and Everett C. Drash, Charlottesville, Va.

Dr. Frank S. Ashburn will be moderator for the Symposium on Bronchogenic Carcinoma, 3:30 p.m. Five specialists will contribute to the subject, each from the viewpoint of his specialty. The speakers are: Drs. Harold Dorn, Harold L. Stewart and Albert W. Hilberg, of Bethesda, Md.; M. Lawrence White, Huntington, West Va.; and Louis K. Alpert, Washington.

The session will close with business meetings at 5 p.m. for each of the two chapters.

Dr. Edward Boland, President of the **American Rheumatism Association,** extends an invitation to any physician attending the FIRST INTERSTATE SCIENTIFIC ASSEMBLY to stay an extra day and attend the **Interim Scientific Session of the American Rheumatism Association,** which will be held at the National Institute of Arthritis and Metabolic Diseases in Bethesda, Md., November 4. A preliminary program may be secured from the Chairman of the Program Committee, Dr. Morris Ziff, 477 First Avenue, New York 16, N. Y. Dr. Darrell C. Crain is Chairman of the local Committee on Arrangements.

Listed below are the **Postgraduate Courses** arranged by the **American College of Physicians** which will be held on or near the Eastern Seaboard during the autumn months.

October 11–15: Basic Concepts in Internal Medicine. Medical College of Virginia, Richmond, Va. Drs. Charles M Caravati and Kinloch Nelson, *Co-directors.*

October 11–15: Newer Developments in Cardiovascular Diseases. Mt. Sinai Hospital, New York. Drs. Arthur M. Master and Charles K. Friedberg, *Co-directors.*

October 18–22: Medical Aspects of Neoplastic Diseases. Memorial Center for Cancer and Allied Diseases, New York. Drs. Cornelius P. Rhoads and Rulon W. Rawson, *Co-directors.*

November 1–5: Physiological Basis for Internal Medicine. University of Pennsylvania Graduate School of Medicine, Philadelphia. Dr. Julius H. Comroe, Jr., *Director.*

November 8–12: Internal Medicine. Beth Israel Hospital, Boston, Mass. Dr. Herrman L. Blumgart, *Director.*

November 8–12: Gastroenterology. University of Pennsylvania Graduate School of Medicine, Philadelphia. Dr. Henry L. Bockus, *Director.*

The registration fee for members is $30, and for nonmembers, $60. Registrations should be made through the Executive Offices of the College, 4200 Pine Street, Philadelphia 4, Pa.

Twelve Washington area physicians will be faculty members at the **James C. Kimbrough Urological Seminar** to be held, September 16–18, at Walter Reed Army Medical Center. Washington physicians are invited to attend.

The seminar is named in honor of Colonel James C. Kimbrough (Ret.), former Chief of the Urology Service at Walter Reed. Upon his retirement from the Army in 1953, he was appointed lifetime Consultant in Urology to the Center by the President of the United States. Director of the course is Colonel Jack W. Schwartz, Chief of Walter Reed Hospital's Urological Service.

The Washington Academy of Surgery will hold its first fall meeting, October 11, 7 p.m., at the Kennedy Warren. As usual, it will be a dinner meeting for members and invited guests. Dr. Harold A. Zintel, of St. Luke's Hospital, New York, will be present to speak on "Surgical Lesions of the Pancreas."

The first fall meeting of the **Philadelphia Proctologic Society** will be held on Thursday evening, September 23, at 8:30 p.m., in the Philadelphia County Medical Society's building, 21st and Spruce Streets, Philadelphia.

The program will consist of a Panel Meeting on Proctology, conducted by the American Board of Proctology, with discussion centering on three topics: Anorectal Infections; Hemorrhoids, Prolapse and Procidentia; and Benign and Malignant Tumors of Rectum and Colon. Dr. Garnet W. Ault, Professor of Proctology, Georgetown University School of Medicine, will be one of the participants in the panel discussions.

Dr. Frank H. Murray, Secretary of the Society, extends a cordial invitation to members of the District Medical Society to attend this meeting.

More than 1,400 physicians attended the **59th Annual Convention of the National Medical Association,** which was held in Washington, August 9–13. This was the fourth annual meeting of the Association in Washington. The Medico-Chirurgical Society of the District of Columbia, of which Dr. W. Montague Cobb is President, was host to the Convention. The facilities of Howard University were used for the scientific meetings.

Many members of the Medical Society of the District of Columbia contributed to the success of the scientific program. Following is a list of the papers they presented at the various sectional and general meetings:

"Blood Flow and Metabolism of the Brain in Health and Disease," Dr. Joseph F. Fazekas

"Hemophilia," Dr. William H. Bullock

"Problems of the Large Baby in Obstetrical Practice," Dr. Coleridge M. Gill

"The Current Status of the Management of Rheumatoid Arthritis," Dr. Darrell C. Crain

"Recent Advances in Cardiovascular Surgery," Dr. Charles A. Hufnagel

"Peptic Ulcer," Dr. R. Kelley Brown

"Endocrine Problems in Obesity and Hirsutism," Dr. Walter L. Henry

"Sickle Cell Hemoglobin C Disease," Drs. Roland B. Scott and Melvin Jenkins

"Pericarditis," Drs. John B. Johnson, Janet Eve and Donald Keller

Symposium on Cancer of the Prostate: Dr. R. Frank Jones, Dr. Roger Baker and Colonel J. C. Kimbrough

"Complications of Acute Pyogenic Infections," Dr. Margaret Grigsby

"Dermatitis of the Hands," Dr. Joseph G. Gathings

"Heart Failure," Dr. Donald Keller

Symposium on Low Back Pain: Drs. Leonard T. Peterson and James P. Murphy; Dr. J. Robert Gladden was moderator

"Chronic Alcoholism: Problems in Etiology and Rehabilitation," Dr. Anthony Zappala

"Accidental Fatal Poisonings in Children," Dr. Katherine Bain and Dr. Marian M. Crane

Symposium on Gastrointestinal Hemorrhage: Drs. Thomas S. Sappington, Ernest A. Gould, Maurice Mensh and David E. Zion

"Addison's Disease (with case demonstrations)," Dr. Riley F. Thomas

"The Therapy of Disability," Dr. Josephine J. Buchanan

Symposium on Headache: Participants included, among others, Drs. Clarence S. Greene and Lester Blumenthal

Dr. Thomas M. Peery presented a Clinico-Pathological Conference before a joint scientific session on medicine and surgery.

At the Grand Opening Meeting, August 10, Dr. J. G. Gathings introduced the President of the Association, Dr. A. Porter Davis, of Kansas City, Kan., who gave the annual Presidential Address. Dr. Davis also spoke at the Public Meeting which was held in the evening, August 10, in the auditorium of the Department of Health, Education and Welfare. Dr. Leonard A. Scheele, Surgeon General of the United States Public Health Service, was the guest speaker at this meeting.

Dr. Peter Marshall Murray, New York gynecologist, received the NMA's Distinguished Service Award. Dr. Murray, President of the Medical Society of the County of New York, is a graduate of Howard University and Past President of NMA.

At the final convention session, Dr. Matthew Walker, of Nashville, Assistant Dean of Meharry Medical College, was installed as President, succeeding Dr. Davis. Dr. A. C. Terrence, of Opelousa, La., is the new President-elect. Dr. Ralph W. Hixson, of Cleveland, was elected Speaker of the House of Delegates, and Dr. John T. Givens, of Norfolk, Va., was reëlected Executive Secretary.

GENERAL NEWS

The first meeting of the **Executive Board of the Medical Society of the District of Columbia** under its new Chairman, Dr. Wallace M. Yater, was held on July 26. A large portion of the meeting was concerned with reviewing the committee appointments made by the new President, Dr. Preston A. McLendon. The new Committee personnel, approved by the Board, appeared in the July issue of the Medical Annals. The Board also approved President McLendon's appointees to various communal activities concerned with health and public welfare in the District of Columbia. The scope of the Society's participation in community projects is well indicated by these appointments, which are enumerated herewith.

In response to a request from Mr. Gerard M. Shea, Director of Public Welfare, District of Columbia, for a member to serve on the Department's Committee on Regulations, President McLendon selected **Dr. C. K. Fraser,** Chairman of the Society's Obstetrical Board.

Dr. George Maksim, Chairman of the Committee on Public Health, was appointed to represent the Medical Society at a two-day meeting in September, to be called by the District Commissioners for the purpose of directing the public's attention to the manner in which it can contribute to the improvement of public health; the meeting will also focus the public's attention on the efforts being made to bring about and maintain better health conditions in the District of Columbia.

The Board approved the appointment of **Drs. W. T. Gibb and Stuart O. Foster,** Chairman and Vice Chairman, respectively, of the Committee on Coöperation with the D. C. Bar Association, to serve as delegates to the Ninth National Conference on Citizenship, sponsored by the Office of the Attorney General. The Conference will be held at the Hotel Statler, Washington, on September 15–17.

Dr. Alfred E. Brigulio was appointed to represent the Society on the First Aid Committee of the American Legion 1954 Convention Corporation of D. C. Dr. Brigulio is Chairman of the Society's Committee on Emergency Medical Care.

The Committee on Public Information recommended that a representative be appointed to serve on the Advisory Council of the Greater Washington Educational Television Association, Inc. **Dr. Josephine Renshaw,** Chairman of the Committee on Public Information, was designated by the Board to serve in this capacity.

The nomination of Dr. James G. Sites to Associate membership on the Obstetrical Board was sent in by its Chairman, Dr. Fraser. Dr. Sites will represent the D. C. General Hospital on the Board, succeeding Dr. George J. Fuchs, Jr., who is in military service. The Board approved the nomination.

The Board voted to propose to the Society the name of Major General Dan C. Ogle, recently appointed Surgeon General of the Air Force, for election to Honorary membership.

The Secretary of the Society reported on the tentative plans of the Program Committee for the ensuing year. The first meeting of the Society is scheduled for Wednesday, October 13, the program to be presented by the Food and Drug Administration. The complete program will be mailed to members of the Society.

Ground was broken on Sunday, August 15, for the new **School of Nursing of Georgetown University.** The ceremony took place near the east end of the University Hospital, on Reservoir Road, N.W. The Very Reverend Edward B. Bunn, S.J., President of the University, turned the first spadeful of earth. District Commissioner Renah F. Camalier spoke in praise of Georgetown's nurses.

The new building, to cost $1,350,000, will be the first to be erected under the Greater Georgetown Fund, the University's 10-year, $14,000,000 development program. Construction was scheduled to begin September 1. The structure will be of brick and limestone, and will have five stories and a basement. It will accommodate 250 women students and 13 faculty members.

The School of Nursing will be the third unit in the Medical Center, which was begun with the Medical-Dental Schools in 1930 and further enlarged with the erection of Georgetown Hospital in 1947.

Major General Dan C. Ogle, USAF (**Medical**), has been named **Surgeon General of the U. S. Air Force,** succeeding Major General Harry G. Armstrong, who has been appointed Surgeon for the U. S. Air Force in Europe.

MAJOR GENERAL DAN C. OGLE, USAF
New Surgeon General of the U. S. Air Force

General Ogle received his medical degree from the University of Illinois College of Medicine in 1929. He graduated from the School of Aviation Medicine at Brooks Field, Texas, in 1931; he also is a graduate of the Medical Field Service School at Carlisle Barracks, Penna., and of the Air War College (1949).

In 1942 General Ogle was named post surgeon of the Technical Training Center, and the following year assumed command of the Army Air Force Regional Station Hospital at Coral Gables, Florida. In 1944 he went overseas to serve as staff surgeon of the 15th Air Force in Italy. He was named

Deputy Surgeon General of the Air Force in 1949 and later was transferred from the Army to the Air Force. In March, 1953, he was named Surgeon for the United States Air Forces in Europe, with headquarters in Wiesbaden, Germany. He assumed his new duties in Washington on July 14.

The District of Columbia Division of the American Cancer Society is distributing more than $62,000 to Washington hospitals and other institutions to assist them in the fight against cancer. This is about $4,000 more than the amount distributed this time last year. The list of institutions benefiting by these awards, which are financed from the local cancer fund-raising campaign last year, are: George Washington University, $18,379.10; Georgetown University, $15,091.56; Howard University, $3,756; Garfield Memorial Hospital, $11,277; Children's Hospital, $3,945; Washington Home for Incurables, $5,000; Episcopal Eye, Ear and Throat Hospital, $3,600.

Episcopal Hospital was also given $1,000 to help operate a speech therapy clinic for patients who must learn substitute ways of speaking when cancer operations have interfered with the vocal mechanism. This clinic was developed last year.

Georgetown University Medical Center reports the receipt of seven individual grants from the U. S. Public Health Service, totaling $106,537. The total amount is divided among the recipients as follows:

Drs. Laurence H. Kyle and Walter C. Hess, $5,000, from the National Institute of Arthritis and Metabolic Diseases, for a study of the "Metabolic Effects of Modified Human Globin."

Dr. Francis M. Forster, two grants of $21,939 and $11,556, from the National Institute of Neurological Diseases and Blindness, for "Teaching and Training Neurology" and "Biochemistry and Multiple Sclerosis," respectively.

Dr. Arnall Patz, $13,610 from the National Institute of Neurological Diseases and Blindness, for studies on the role of oxygen in retrolental fibroplasia.

Dr. Murray M. Copeland, $25,000 from the National Cancer Institute, which is the continuation of a previous grant.

Dr. George N. Raines, two grants of $12,500 and $16,932, from the National Institute of Mental Health, to be used for the continuation of studies under two previous grants.

Dr. Max Thorek, of Chicago, was presented with the Order of Merit, degree of Grand Officer medal, from Argentine Ambassador Hipolito J. Paz, in the name of President Peron, at an Embassy reception, August 11, attended by many distinguished physicians and by high diplomatic officials of both the United States and South America.

Dr. Thorek is Professor of Surgery at the Cook County Graduate School of Medicine in Chicago; founder and Secretary-General of the International College of Surgeons; and Surgeon-in-chief of the American Hospital, Chicago. He was recognized for his outstanding services as a physician and for the work he has done "in promoting international solidarity between the two countries."

Among the physicians present for the ceremony and reception were Drs. George F. Lull and Austin Smith, of the American Medical Association, Chicago, and Drs. Virgil T. deVault, Leonard A. Scheele, Wallace M. Yater, and James W. Watts, of Washington.

Dr. Charles D. Shields has been appointed Professor and Chairman of the Department of Physical Medicine and Rehabilitation at **Georgetown University School of Medicine,** effective August 12.

Dr. Shields graduated from Georgetown Medical School in 1934 and received the Master of Public Health degree from Harvard University in 1937. He engaged in the private practice of medicine in Buffalo in 1940–41. During World War II he served in the North African Theater and in Italy, where he was Chief of Hospitals and Medical Care Section of the Allied Control Commission.

Leaving the Army in 1946, he was Commissioner of Health in Buffalo, but returned to military service in 1947. He served at Walter Reed and Brook Army Hospitals and at the Medical Field Service School, Fort Sam Houston, before joining the Office of the Surgeon General. Since July, 1953 he has served in the Professional Division of the Office of the Surgeon General as physical medicine consultant, with the rank of Colonel.

Mr. Jesse R. Barnet was appointed **Executive Secretary of the Social Hygiene Society** in August, succeeding Mr. Ray H. Everett, who retired early this summer. Mr. Barnet is a native of Albany, New York, and graduated from New York State College for Teachers. He received his Master's degree from the Harvard Graduate School of Education and was awarded a fellowship in public administration at Harvard. He was formerly Administrative Assistant to the Deputy Commissioner of Education in New York State; last year he was Research Assistant on the Kellogg Foundation Community Studies project at Harvard.

FRENCH NURSE OF DIEN BIEN PHU VISITS WALTER REED

Lt. Genevieve de Galard-Terraube, "the angel of Dien Bien Phu," is shown during her visit to Walter Reed Army Medical Center. She was greeted by Major General Leonard D. Heaton (left), Commanding General of the Center, and Major General George E. Armstrong, Surgeon General of the Army.

Lieutenant Genevieve de Galard-Terraube, the gallant French nurse who won international acclaim for her treatment of wounded at Dien Bien Phu, visited the United States in July and August at the special invitation of Congress. On July 29 President Eisenhower pinned on her the Medal of Freedom, which can be conferred only by the President or by the Secretaries of State, Defense, Army, Navy and Air Force.

At Walter Reed Army Medical Center, July 28, she was greeted by Major General Leonard D. Heaton, Commanding General of the Center, and Major General George E. Armstrong, Surgeon General of the Army. She toured operating rooms and recovery wards of the Hospital and talked with patients.

Lt. de Galard-Terraube was honored by the American Medical Association and the American Hospital Association during her stop-over in Chicago, August 3. More than 100 representatives of medical, health, government and nursing organizations attended the reception in her honor at the Drake Hotel. She was presented with a framed citation which referred to her as "a 20th century symbol of the traditions established by Florence Nightingale." She also received high honors from officials in New York, Cleveland and San Francisco.

Dr. Robert Dexter Lincoln has been appointed consultant psychiatrist for the **District's Child Welfare Division,** the first to hold this position. Dr. Lincoln, who has been on the staff of the Sheppard-Pratt Hospital at Towson, Md., will serve on a part-time basis, according to Acting Welfare Director Donald Brewer.

Prior to his Maryland post, Dr. Lincoln was a Public Health Service psychiatrist at the Springfield (Mo.) medical center for Federal prisoners. He is a graduate of Tufts Medical School and is specializing in child psychiatry.

Washington physicians will be interested in learning that a former member, **Dr. Harry F. Dowling,** Head of the Department of Medicine at the University of Illinois, is heading up studies at Illinois' Statesville Prison on how long a common cold gives immunity to another cold. The Armed Forces Epidemiological Board has approved the research project. In a second phase of the test program, the convict volunteers will aid in an effort to find a relationship between humidity and temperature and the common cold. An Army grant of $36,000 has been awarded for these special studies on the common cold.

PERSONALS

Dr. Thomas McPherson Brown, Professor of Medicine at George Washington University School of Medicine, has been appointed to membership in the Council on Pharmacy and Chemistry of the American Medical Association. This Council, which is composed of 16 outstanding medical scientists and physicians throughout the United States, is responsible for evaluating the evidence of effectiveness and safety of new drugs. Its annual published report, "New and Nonofficial Remedies Accepted by the Council on Pharmacy and Chemistry," is well known to physicians.

Dr. Edward D. Freis, Adjunct Professor of Medicine, Georgetown University School of Medicine, will be one of a panel of distinguished internists to conduct a televised Symposium on the Management of Hypertension from CBS Studio No. 60, New York City, 6 to 7 p.m., E.D.T., September 23. The receiving station in Washington for this closed circuit telecast will be the Sheraton Park Hotel. The program has been arranged by the American College of Physicians and television facilities have been secured through the coöperation of Wyeth, Inc. of Philadelphia.

Dr. R. Lomax Wells, Medical Director of the Chesapeake and Potomac Telephone Companies, is on the planning committee for an Industrial Nursing Institute sponsored by the Catholic University of America, the American Association of Industrial Nurses, and the Metropolitan Washington Industrial Nurses Association, to be held on the Saturdays of October 23 and 30, at the Catholic University of America in Washington. **Dr. Robert J. Coffey,** Professor and Director of the Department of Surgery, Georgetown University School of Medicine, will be one of the physician participants in the program.

Dr. Daniel Blain, Medical Director of the American Psychiatric Association, has been named to a new 13-member committee which will study Federal aid to public health. The Commission on Intergovernmental Relations announced the appointment, July 10. The committee will recommend to the Commission how much Federal public health aid should be granted to state and local governments; it will also study other aspects of the problem. Dr. Franklin D. Murphy, Chancellor of the University of Kansas and former Dean of its Medical School, will head the group. Dr. Edward J. McCormick, Past President of the American Medical Association, is one of the committee members.

Lieutenant Mor J. McCarthy, MC, USN, has received the Navy Commendation Ribbon with Metal Pendant for his work as a surgeon during the Korean War. He was cited for meritorious achievement while serving with a Marine Corps infantry battalion in Korea. The presentation was made, July 19, by Rear Admiral L. O. Stone, Commanding Officer of the Medical Center. Lt. McCarthy, a graduate of Georgetown University School of Medicine, entered the Navy in 1952. He has been stationed at the Naval Medical Center, Bethesda, since his return from Korea in March.

Dr. William Kurstin, President of the Diabetes Association of the District of Columbia, Inc., has been appointed Chairman of the Diabetes Detection Drive for Washington and suburban areas by its Executive Board. The Diabetes Detection Drive will be held the week of November 14–20.

Dr. I. Phillips Frohman has been invited to address the American Medical Writers' Association at its 11th Annual Meeting at the Hotel Sherman in Chicago, September 24. Dr. Frohman, who will participate in a Symposium and Panel Discussion on Medical Writing, will speak on "Medical Writing and General Practitioners."

On September 22, Dr. Frohman will address the Ohio Academy of General Practice, in Columbia, on "TB and the General Practitioner."

Several members of the Medical Society of the District of Columbia assisted in presenting the program before the **Fifth Annual Conference of the American Association of Rehabilitation Therapists,** which was held at the Willard Hotel, Washington, August 23–27.

Dr. A. B. C. Knudson, Director of Physical Medicine and Rehabilitation Service, Veterans Administration, presented a paper on "Basic Concepts in Medical Rehabilitation." **Dr. Frederick J. Balsam,** also of the VA Central Office, was moderator for a panel discussion on Methods for Improving Nonacademic Training through Professional Educational Technics. Dr. Knudson was also master of ceremonies at the banquet, August 26. Drs. Knudson and Balsam are Associate members of the District Medical Society.

The morning session, August 25, was devoted to geriatrics. **Dr. Edward J. Stieglitz** gave an address on "The Challenge of Longevity." In a panel on Problems of an Aging Population, **Dr. Joseph W. Still,** Assistant Professor of Physiology, George Washington University School of Medicine, contributed a paper on "Physiology of the Aging Process."

Rehabilitation Problems of the Long-term Patient was the topic for discussion at the morning session, August 26. **Dr. David Leibovici,** Medical Director of the Upshur Street Hospital, discussed "Rehabilitation Problems as Found at the Upshur Street Hospital."

Dr. Harold Jeghers, Professor and Director of the Department of Medicine, Georgetown University School of Medicine, addressed the annual meeting of the Catholic Hospital Association in Atlantic City, New Jersey, May 17. He spoke on "Joint Responsibility of the Hospital and Medical Staff for Good Medical Care."

Dr. James Q. Gant, Jr. has just been notified of the unusual honor of having a lunar crater named for him. Dr. H. Percy Wilkins, Director of The Lunar Section of the British Astronomical Association, recently announced that "The lunar crater Archimedes-A will henceforth be known as Lunar Crater Gant, in honor of Dr. James Q. Gant, Jr. of Washington, D. C., in recognition for his observations of lunar surface details over many years."

Dr. Gant, has long been avocationally interested in astronomy. He has his own observatory with a good-sized telescope and has been carrying on research in observation of the moon since 1920.

The ANNALS staff is indebted to Dr. J. Russell Fields for submitting this interesting news item. Dr. Fields commented regarding his colleague, "This is quite a distinct honor that has been conferred upon him by internationally recognized authority on lunar study."

Dr. and Mrs. C. Willard Camalier, Sr., recently returned from a trip abroad on the *U.S.S. United States,* having toured Holland, France, Switzerland, Italy and England. Dr. Camalier, Past President of the American Dental Association, was a delegate of the A.D.A. to the meeting of the Federation Dentaire Internationale, held in Scheveningen, Holland.

Lieutenant J. Blaine Fitzgerald, MC, USNR, will open his office for the practice of internal medicine, October 1, at 8218 Wisconsin Avenue, Bethesda 14, Md. His tour of duty with the Navy will be completed on September 30.

Dr. Tiffany Lawyer, Jr., who for the past year has served full-time as Assistant Professor of Neurology at Georgetown University School of Medicine, left Washington, August 31, to return to New York City, where he will assume the position of Chief of Neurology Division at Montefiore Hospital.

ERNEST ELVIN HADLEY, B.S., M.D., F.A.C.P.

(1894–1954)

Dr. Ernest E. Hadley, nationally known psychoanalyst and writer in the field of psychiatry, died, August 10, 1954, at Doctors Hospital. His home was at 4303 Forest Lane, N.W., and his office at 1835 Eye Street, N.W.

Dr. Hadley was born in Alton, Kansas, August 2, 1894, the son of John McC. and Luella Marshall Hadley. He received the degree of Bachelor of Science in Medicine from the University of Kansas in 1918 and his medical degree from the same institution in 1920. After a year's internship at Walter Reed Army Hospital, he accepted a full-time position on the psychiatric staff of St. Elizabeths Hospital, which he held until 1929, when he resigned to enter private practice.

At the time of his death Dr. Hadley was President of the Washington Psychoanalytic Society. He was Director of the Washington Psychoanalytic Institute and consultant to the Corporate Foundation for Research and Training in Psychiatry.

He was one of the organizers of the William Alanson White Psychiatric Foundation, and from 1933 to 1945 was trustee and Secretary. He formerly was Secretary of the Board on Professional Standards of the American Psychoanalytic Association, and from 1936 to 1943 was Director of the Washington School of Psychiatry.

In recognition of his work as Chairman of the Psychiatry Panel of the Army Induction Board at Fort Myer from 1942 to 1944, he received the Selective Service Medal from President Truman.

Dr. Hadley was elected to Active membership in the Medical Society of the District of Columbia in 1930. He was a Fellow of both the American College of Physicians and the American Psychiatric Association, a member of the American Medical Association, the American and International Psychoanalytic Associations, the George M. Kober Medical Society, the History Science Society, the American Sociological Association, and others. He held membership in the University Club and the Washington Golf and Country Club.

For many years a contributor of reviews and treatises to scientific magazines, Dr. Hadley was co-editor of *Psychiatry* from 1938 to 1945.

Dr. Hadley is survived by his wife, Mrs. Agnes Marie Hackerott Hadley, who was President of the Woman's Auxiliary to the Medical Society in 1952–53; three daughters, Mrs. W. W. Eldridge III, of Baton Rouge, La., Mrs. Joseph D. Jeffrey, of Philadelphia, and Mrs. C. Stanley Lowell, of Virginia Beach, Va.; and a brother, William Z. Hadley, of Osborne, Kan.

ROBERT ANDREW KEILTY, M.D.

(1885–1954)

Dr. Robert A. Keilty, Washington pathologist, died, July 19, 1954, at his home, 16 West Lenox Street, Chevy Chase, Md., after a long illness. He had maintained his own medical research laboratory from 1927, when he came to Washington, until about two years ago. For 15 years he was consulting pathologist to Veterans Administration (Mount Alto) Hospital.

Dr. Keilty was born in Smithfield, Rhode Island, January 27, 1885. He attended Roxbury Latin School in Boston and graduated from the University of Pennsylvania in 1907. At the University of Pennsylvania he was one of the founders and presidents of the Delta chapter of Sigma Phi Epsilon fraternity.

After receiving his medical degree he interned at Lancaster General Hospital, Lancaster, Pa., for a year and for another year at the Philadelphia General Hospital. He was pathologist to Philadelphia General, University, Gynecean, and Howard Hospitals, Philadelphia, from 1911 to 1917; during the same period he was Instructor in Pathology at the University of Pennsylvania. He was also Medical Inspector for the Philadelphia Department of Health from 1910 to 1913.

During World War I he served as Major in the Army Medical Corps and in 1919 he was in charge of pathology at the Military Medical Schools at Fort Oglethorpe, Ga. He was a member of the Selective Service Medical Advisory Board in World War II.

After World War I he moved to Danville, Pa., where, from 1919 to 1927, he was Director of Laboratories and Research Medicine at Geisinger Memorial Hospital and Director of Laboratories for the State Hospital for the Insane. He was a member of the Pennsylvania State Committee on Laboratories from 1923 to 1927. Reports on his extensive research on thyroid and gingivitis received wide attention. He came to Washington in 1927 to serve as consulting pathologist to the U. S. Veterans Bureau in charge of The Diagnostic Center Laboratories.

He was an Active member of the District Medical Society since 1928, and a member of the American Medical Association, the American Society of Clinical Pathologists, and the Hippocrates-Galen Medical Society.

Dr. Keilty was also very well known among sportsmen as a golfer. He had been President of the Maryland, District, and Middle Atlantic Golf Associations and had served as Executive Secretary of the latter association since 1938. He helped to develop the Middle Atlantic senior championship tournament as an annual event at the Burning Tree Country Club. He was a member of the Board of Governors of the Congressional Country Club for 15 years.

He is survived by two daughters, Major Madeleine E. Brown, of Elgin Air Force Base, Fla., and Mrs. John Barber, of the home address; a brother, Charles Roe Keilty, of Oklahoma City, Okla.; and a sister, Miss Madeleine D. Keilty, of Chevy Chase, Md.

HERMAN EUGENE KITTREDGE, M.D.

(1871–1954)

Dr. Herman E. Kittredge, retired Washington dermatologist, died, June 24, 1954, in Garfield Hospital. He had made his home the past several years at Oakhaven, Clinton, Md.

Dr. Kittredge was born in Walden, Vermont, November 19, 1871. He graduated from Columbian (now George Washington) University in 1901 and began practicing medicine in the District of Columbia the same year. As clinical assistant to the late Dr. Randolph Bryan Carmichael, dermatologist, Dr. Kittredge studied diseases of the skin and later confined his practice to that specialty. He became Clinical Instructor in Dermatology at George Washington University School of Medicine, and for many years was on the staff of several Washington hospitals as consultant in dermatology. His offices were last located in the Columbia Medical Building.

A poet and writer, Dr. Kittredge published two books of poetry and was a member of the Eugene Field Poetry Society. He was best known for his "A Biographical Appreciation of Robert G. Ingersoll."

Dr. Kittredge was an Active member of the Medical Society of the District of Columbia from 1925 until he retired from active practice in 1947. He was a member of the American Medical Association and the Washington-Baltimore Dermatological Society.

Surviving him are his wife, Mrs. Eugenie DeGuerin Kittredge; two sons, Robert I. Kittredge, of Washington, and Alanson M. Kittredge, of Silver Spring, Md.; a daughter, Mrs. Lilla T. Martin, of Dover, N. J.; and a sister, Mrs. Vira D. Harrington, Melrose, Mass.

Lymphatic Spread of Bladder Cancer and Surgery—Baker

(*Continued from page 479*)

metastases to regional pelvic lymph nodes, but also did not spread for any considerable degree to adjacent lymphatics within the bladder wall. Usually, however, neither of these conditions obtained for this group of infiltrative cancers. Tumor cells usually involved 60 per cent or more of the circumference of the bladder, and there were tumor-bearing lymph nodes in about 80 per cent of cases.

The advantages and disadvantages of transurethral resection or the routine segmental resection are discussed. The rationale for hemicystectomy in conjunction with lymphadenectomy is presented.

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New Infant Food Formula—Oberman and Burke

(*Continued from page 488*)

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Neuroses Following Trauma—Laughlin

(*Continued from page 502*)

partially hidden conflicts can have a painful, traumatic impact. Although this must be faced and dealt with in treatment, i.e., conflicts must be recognized and resolved, many people are openly or intuitively unwilling to face this discomfort and pain even though it is temporary, ultimately constructive, and a necessary requisite to later greater comfort. If one can understand a patient's reluctance to see his dentist, one can very readily understand his often much greater resistance to face the much greater discomforts which he may have to bear in psychotherapy. In the latter instance, also, his reluctances are apt to be obscured and disguised by all kinds of rationalization. Further, unlike the dental surgeon or the medical surgeon, the psychiatrist has no anesthesia to offer, nor can he hire an anesthetist.

(*To be continued*)

6800 Hillcrest Place
Chevy Chase 15, Md.

Prestige Score—Observer

(*Continued from page 534*)

"But the businessman is rated above the author. Is that because Americans don't appreciate books or because they do?"

Mr. Livingston was asked for further details regarding this study. He kindly furnished photostats of Professor Hatt's statistical tables, which proved unintelligible to your Observer. However, they are impressive evidence of serious effort, and, where physicians are concerned, should be refreshingly pleasant.

T. W.

Grievance Committee Case Reports

(*Continued from page 536*)

tee were unanimous in the opinion that Dr. J was not blameless for the misunderstanding which had arisen between himself and Mr. B. They did not doubt that he had tried to telephone Mr. B, but it did not seem reasonable that with a little perseverance he could not have reached him. At the very least, Dr. J should have notified the Bureau on Saturday of his inability to contact Mr. B.

It also seemed to the Committee that while the statements credited to the receptionist were perhaps exaggerated, it was apparent that her handling of this matter could have been improved upon.

The Committee felt that Mr B should be informed that the doctor was justified in limiting the boundaries of his practice and advised to select a family physician in his immediate neighborhood. Mr. B should also be enlightened in regard to the ethics involved.

It was also agreed that Mr. B should be informed that regardless of circumstances Dr. J would have responded had he been given to understand that there was an emergency.

Summary. All in all, the Committee concluded that Dr. J was a conscientious physician whose lapse in judgment, coupled with his receptionist's want of tact, had contributed to a misunderstanding.

Mr. B was undoubtedly a "shopper," as Dr. J said. As such persons often are, he was touchy and therefore easily offended.

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SOME CONCEPTS OF FOOD ALLERGY*

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IN 1924 Dr. Richard C. Cabot published a book entitled "What Men Live By—Work, Play and Love." This title need well be amended to include food. Food has figured at all times, and especially in our own, as an important economic and social factor. In the animal kingdom the quest for food has been responsible for migrations and in some instances has led to extinction of species. It is obvious that in the human, individual growth and even life itself is dependent upon adequate food intake. In the allergic individual, however, there appears a striking paradox in that some foods give rise to a train of distressing symptoms and even death.

I hesitate to repeat the time-worn aphorism: "What is one man's meat is another man's poison." Accordingly, the diet of the allergic patient assumes importance only if his sensitizations include a food or foods. Food, or ingestant allergy, unlike inhalant allergy, presents many anomalies. The gastrointestinal tract is the first site of interaction between allergen and sensitized cells; and the manifestations of gastrointestinal allergy include such symptoms as nausea, vomiting, intestinal cramps, and diarrhea. The specific food allergen may, however, provoke symptoms in other tissues and organs of the body to which it is transported by the blood stream. The disfiguring and frightening edema of face, of buccal and laryngeal mucosa, of arms and of legs may at times result from such dissemination. Accordingly, symptoms referable to the skin, the upper and lower respiratory tract, the central nervous system, the joints, the cardiovascular system, and the genitourinary system have been attributed by various authors to food allergy. The clinical entities, migraine, vasomotor rhinitis, asthma, eczema, urticaria, and angioneurotic edema have been cited as abnormal reactions resulting from the ingestion of allergenic food substances.

"The results of food allergy occur in nearly every system and part of the body." This statement of Rowe's is re-echoed in the following declaration of L. P. Gay: "Food allergy also is a superb mimic and has the capacity of reproducing the entire symptomatology of practically any organic disease." A warning note, however, is sounded by Prickman, who says: "The attempt should not be made to explain as allergic all diseases or symptoms of an allergic individual. The allergic patient may have bunions, gallstones, hypertension, neuroses, dyspepsia or psychoneurosis, just as the nonallergic individual may have them." Consequently, a challenge and a responsibility are thrust upon the allergist. The challenge for a correct diagnosis of a possible food allergy is presented by every allergic patient, and the responsibility for minimizing or abolishing his symptoms of distress is one from which the physician cannot escape.

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* Delivered at the Decennial Graduate Instructional Course in Allergy of the American College of Allergists in Miami Beach, Florida, April 7, 1954.

Unfortunately, a survey of the literature reveals a sharp difference of opinion regarding the diagnostic procedures in food allergy. Agreement is unanimous that the cutaneous and intracutaneous methods of testing with food extracts have their limitations. Extracts of foods which cause clinical symptoms frequently do not give positive skin reactions. The reverse also holds true: Foods which give positive skin reactions fail upon ingestion to produce symptoms. The high percentage of false negative and false positive reactions has cast a doubt upon the value of this test.

My judgment is that cutaneous tests with potent food extracts, carefully performed and adequately controlled, are helpful and will occasionally yield significant information. Positive skin reactions are comparable with the traffic signs on our highways, which are designed to attract and direct the motorist. Positive skin reactions are especially useful in supplementing clinical history. There are two questions I ask of my patients: "Are you aware of any food which will provoke or aggravate the symptoms you have described?" "Is there any food which causes itching of the lips or tongue?" A discussion of the answers is likely to reveal possible food idiosyncracies.

The clinical history is, indeed, an important link in the chain of evidence in the diagnosis of food allergy as it is in the diagnosis of other diseases. An adult of average intelligence is fully cognizant from repeated experiences of the food or foods which give rise to symptoms of distress. Anxious mothers are always on the alert for the possibilities of food intolerance in their youngsters and offer incontrovertible testimony. Patients who are sensitive to the powerful allergenic foods, such as milk, egg, fish, shellfish, and nuts, have recognized the promptness with which reactions follow ingestion or even contact. The information acquired by skin tests may help to correlate delayed symptoms due to the skin-positive reacting foods. A diary listing the foods ingested over a period of 1 to 3 weeks and a daily record of symptoms, if any, may also serve a similar purpose.

Food likes and dislikes sometimes play an important role in food allergy. Children especially are prone instinctively to refuse foods to which they are allergic. One of my patients, a boy aged 8, will painstakingly remove nuts from candy bars and cakes. He is fully aware of the coughing and asthmatic seizures which accompany the eating of nuts.

There still remains a group of patients in whom the ingestion test or so-called "therapeutic trial" is the sole means of determining food-sensitiveness. The clinical history may be vague or indefinite. The cutaneous tests with food extracts may be inconclusive, as previously indicated. Under these circumstances, the ingestion test, it is agreed, offers a more accurate and specific means of diagnosis of food allergy. Several dietary methods have found acceptance. One of the oldest procedures was to place the patient on a starvation diet for one to three days. He was then given a diet of rice and tea. Other foods were gradually added, one at a time, and the reproduction of such symptoms as ensued were carefully noted.

Several modifications of the ingestion test have been introduced. For some patients an initial diet is prescribed which consists of the negative-reacting foods. The clinical course is observed during this trial period. Observation is continued when the diet is increased, first by test-negative and later by test-positive foods. It is upon this principle that Rowe's "elimination diets" have been based. They were first published in 1928. These are standardized diets which can be readily used in the diagnosis and treatment of food allergy. All of the common foods, especially wheat, egg, and milk, are omitted. The diets are modified according to the food history and skin reactions. They include foods which rarely or infrequently produce allergy in average patients. Rowe is of the firm conviction that "trial diet is of greater importance than skin-testing."

The diet, proposed by Andressen, is the very antithesis of Rowe's. It consists of wheat, milk, egg, beef, potato, orange, and salt—common causes of allergy. A patient sensitive to any food in the list will promptly develop symptoms. The offender can readily be traced from this small group of foods. If there is no aggravation of symptoms within the first 2 days, the patient is advised to continue with it for 1 week. If at the end of this period there is an amelioration or disappearance of symptoms, other foods are added singly at 3-day intervals and the reactions carefully interpreted.

Randolph, in a desire to improve "current outmoded methods of specific food diagnosis," advocates the following procedure:

1. A period of 4 days during which the test food is ingested;
2. A succeeding period of 4 days of abstinence from the test food;
3. The ingestion of the single test food on a fasting stomach the following morning;
4. The observation of resulting signs and symptoms.

The Randolph method when applied to several foods of necessity requires an extended period for experimentation. The variation in the occurrence and intensity of symptoms, so characteristic of chronic diseases, may be due to causes other than food sensitiveness. Moreover, the influence of psychic factors during such a prolonged investigation must not be overlooked. There are many allergic persons who are so sensitized to suggestion that their expression of food disagreements must be evaluated. Such attitudes are betrayed when in consultation they exclaim: "Why the very thought of that food makes me sick." The reliability of the ingestion test is enhanced by excluding or minimizing psychic factors. The "blindfold" technic, wherein the identity of the test food is unknown to dispenser and patient, offers that opportunity. Moreover, the suspected food ingested on a fasting stomach must reproduce allergic symptoms attributed to it. The symptoms provoked by such ingestion are determined by the affected "shock organs"—the respiratory tract, the gastrointestinal tract, or the skin.

In 1934 the leukopenic index, a laboratory aid in the diagnosis of food allergy, was advanced by Vaughan. The method consists of taking white blood cell counts before and after eating a normal quantity of a single food to be tested. A drop of 1,000 cells or more below the lowest fasting count is regarded as a positive index of allergy. Vaughan stressed the defects of skin-testing with food allergens and concluded that the digestion leukopenia overcame the objections. The leukopenic index as a diagnostic means has had enthusiastic supporters and severe critics. Alvarez, in a discussion of "Specific Food Sensitiveness," gave expression to an opinion which was not based on experimental evidence. The opinion reads: "It seems to me that we can save time and expense by testing each food by its reactions on the patient's comfort and not on his white count."

Such a review of the ingestion tests as we have made should include the first one described in Holy Script. In verse 3, chapter 3 of the Book of Genesis, Eve was admonished not to eat of the fruit of the tree which was in the midst of the garden. "Ye shall not eat of it, neither shall ye touch it, lest ye die" was the stern command. Verse 6 records: "The woman saw that the tree was good for food, . . . she took of the fruit thereof, and did eat, and gave also unto her husband with her and he did eat." The reactions which have since taken place have become a matter of recorded history.

It may not be amiss to present some of the concepts which have a bearing upon the important question of food allergy. According to one school of thought, there is an increased permeability of the intestinal wall, wrought by injury or weakened by some digestive disturbance, which permits the passage of unaltered proteins into the circulation. Another school maintains that in the allergic patient digestion is not complete and that intermediate products of protein disintegration are absorbed which are responsible for the reactions. Conversely, in the normal individual the protein molecule is broken down into amino acids. LaRoche, Richet and Saint Girons have summarized their conception as follows: "Food anaphylaxis is an intoxication. Substances not sufficiently modified pass through the intestinal barrier and the liver does not stop them sufficiently. They provoke an intoxication of the organism, especially of the blood, and they modify the internal secretions and vagosympathetic tonus. The symptoms are the more marked, the greater the vagosympathetic instability." This conception neither explains the failure of the normal individuals to exhibit reactions, nor does it explain the selective actions of certain foods to which the allergic individual is sensitive.

In 1939 the Allergens Research Division of the United States Department of Agriculture reported the isolation of an active allergenic fraction from cottonseed which was designated CS-1A. Later a purified fraction of CS-1A was obtained and designated CS-13 Endo.

In 1942 evidence of the presence of the multiple cottonseed reagins and of multiple cottonseed allergens was presented. The question of multiple allergens was accordingly removed from the realm of probability to the realm of actuality. In confirmation, the investigation of the nature of the unidentified allergens of cottonseed was a logical sequence. Globulin fractions of cottonseed, prepared after prolonged purification, retained allergenic activity. Moreover, in the course of routine testing, 2 of my patients exhibited reactions of extraordinary interest. They reacted positively when tested with whole cottonseed and unheated globulin preparations, and negatively when tested with the potent fraction CS-1A. Their blood reagins were likewise specific for the globulin fraction.

The technic involved in the isolation of the principal allergenic component of cottonseed has been successfully applied to several of the oil-bearing seeds, almonds, Brazil nuts, coconut, filbert nuts, peanuts, soybeans, etc. This contribution is of fundamental importance in demonstrating that foods when ingested carry with them the allergen or allergens which react with the sensitized cells. It has been well established that the union of allergen and antibody is an explosive one, with resulting symptoms. I cannot accordingly subscribe to the view that clinical sensitization to protein digestion derivatives is the only basis of allergic phenomena. A recent contribution by Bloom, Markow and Redner is noteworthy. These authors tested allergic patients selected at random with 10 foods. Each patient was tested with a standard extract, pepsin digest and trypsin digest in equal concentrations. The intracutaneous tests were supplemented with intentional feeding tests with each of the foods under study. The results of the skin tests with the standard extracts, compared with their pepsin and trypsin digests, indicate possible changes in the antigenicity of foods due to digestion. However, their conclusion is significant: "The results of this limited study suggest that changes in the antigenicity of foods as a result of digestion, as indicated by skin tests and intentional feeding tests, are an infrequent occurrence."

Spies has called attention to certain inherent difficulties in the study of the effects of digestion upon suspected allergenic foods which must not be overlooked. He lists them as follows: the indefinite nature of protein hydrolytic products, the possible presence of immunologically significant traces of undigested native protein in enzyme digests, the use of complex foods, the lack of determination of the degree of enzyme digestion, and other difficultly controlled factors. Accordingly, the effect of enzyme digestion upon the purified fraction of CS-1A, the principal allergen from cottonseed, is significant. This allergen was subjected to the action of 4 crystalline enzymes: trypsin, chymotrypsin, pepsin, and carboxypeptidase.

1. The allergen was digested by all of these enzymes.
2. Pepsin and carboxypeptidase, however, digested the allergenic fraction to a lesser degree than did trypsin or chymotrypsin.
3. Skin-reacting capacity was destroyed by trypsin, but not by pepsin or carboxypeptidase.
4. The peptic digest of the fraction was antigenic.

The foregoing complexities of the subject of food allergy are increased by an analysis of the behavior of food allergens under certain conditions.

A remarkable physical property of the allergenic protein fractions, CS-1A and CB-1A, isolated from the cottonseed and castor bean respectively, is their resistance to heat. Thus, CS-1A, dissolved in water and autoclaved at 125° to 130° for an hour, gave positive cutaneous tests in the dilution $1:10^5$. Clinical evidence will now be presented to attest to the concept that the physicochemical characteristics of allergenic fractions not only vary from each other in different substances but vary from each other in the same substance.

A patient was tested by the cutaneous method with an extract of celery. The reaction was strongly positive. The typical wheel with pseudopod formation was accompanied with considerable itching. The patient then exclaimed: "That is what happens to my lips when I eat raw celery. But I can eat cooked celery as in soups without any trouble." It is apparent that one allergen in celery is heat-labile in contradistinction to the heat stable allergens, CS-1A and CB-1A. The classic observation of Prausnitz and Kustner in their work on passive transfer stands out in marked contrast. Kustner, it will be recalled, was fish-sensitive. Uncooked fish produced no allergic disturbances in him, but fish when cooked and subjected to a temperature of 55°C. became actively allergenic. In fact, cutaneous tests, positive with a boiled extract, provoked constitutional reactions.

By way of supplement, the case history of a male patient, aged 42, may well be cited. Ever since he was a boy of 7, he could not eat fish either in the raw or cooked state. Extensive angioneurotic edema developed within 5 to 10 minutes after ingestion. He could, however, eat canned salmon or canned tuna fish without any untoward symptoms.

It may, therefore, be concluded from the foregoing clinical experience that the multiple allergens in fish show a difference in susceptibility to temperature changes. Some are active in the fresh state, some are activated by a temperature of 55°C., and all are inactivated by the temperature of the canning process. Fish are cold-blooded animals and their temperature is determined by that of their environment. This varies from the icy waters of the Arctic to the warm waters of the Torrid Zone. The question naturally arises whether allergens in fish vary with or conform to habitat.

It must be obvious that no set rule can be formulated for the detection of the offending food or foods in sensitive patients. A combination of methods under discussion may be necessary. Every allergist learns to profit by his experience and will select a program best suited to his needs and to his particular class of patients. Treatment is instituted after the identity of the allergenic foods has been established. It consists primarily of the elimination of the food or foods presumably responsible for symptoms. An adequate diet must be prescribed to prevent loss of body weight, and the addition of vitamins is essential. In the case of infants, whose normal diets are naturally restricted, modifications or substitutes become a matter of urgency.

The physician is inevitably confronted with an enigma when the patient asks the question: "How long must I give up the food?" The period of abstinence may extend over many years. Rinkel's classification of food sensitization as cyclic or intermittent in nature and fixed or constant in character is a timely one. In some patients, loss of sensitization occurs after a short period of avoidance, provided the tissue cells are not stimulated by repeated exposure to the allergen.

Some authors have advocated oral or parenteral desensitization with some foods, as egg, milk and wheat. Desensitization by means of the hypodermic injection of food extracts follows the same principles as are applied to desensitization with pollen extracts. Supportive treatment by the administration of dilute hydrochloric acid and pepsin or the use of pancreatin with trypsin should be borne in mind for patients who exhibit subacute or chronic gastrointestinal disturbances.

The European school has recommended the oral use of peptones, derived from various animal and plant foods. They are administered in small amounts one hour prior to each meal and are designed to create a state of antianaphylaxis. Urbach's propeptans represent an elaboration of this method. The conclusion, however, has been reached by many of our observers that the results of desensitization therapy in food allergy are as a rule not effective and do not justify the expenditure of time and effort. Complete avoidance of the allergenic food for an experimental period of time is the treatment of choice.

In the case of the allergic patient there are factors pertaining to his diet other than the elimination of the allergenic food which command attention. This is notably true of asthmatic victims. Patients should be warned not to eat so-called "hearty" or heavy meals. Moreover, they should be discouraged from eating solid food immediately before retiring. "Too full for words" denotes interference with the normal movements of the diaphragm as the result of a distended stomach, and an encroachment upon pulmonary ventilation. To the chronic asthmatic with distended lung alveoli, contracted bronchioles and a tenacious secretion within them, such encroachment adds to his distress. Small and frequent meals will relieve the condition.

Consideration must also be given to the heat regulating mechanism of the allergic patient, particularly so in the case of the asthmatic and hay-fever victims. In the normal person, any change in heat production and heat loss brings about a compensating change in the other. In the allergic, however, the "thermostat," so to speak, is deranged. Accordingly, heat loss is accompanied by a constriction of the superficial blood vessels and by an abnormal engorgement of the turbinates in the nasal chamber and of the vessels of the respiratory tract. Stuffiness of the nose, sneezing, a sense of constriction of the chest, cough and wheezing are the signs and symptoms of a reaction to loss of body heat. The manner in which these changes are effected is least suspected. The ingestion of iced beverages, iced foods, especially ice cream, popsicles, and the sucking of ice cubes result in chilling. The warmer body inevitably gives off its heat to the cooler surroundings. Newton's law concerning the rate of heat emission between surface and surroundings is not to be defied.

A former patient, a young physician with asthma of a severe type, when cautioned against the use of iced beverages, declared: "I now understand why the drinking of iced orange juice at breakfast has always been followed by an asthmatic attack." A frequent occurrence is a sleepless night for asthmatic children and members of the family when ice cream is served at bedtime. I advise patients to remove ice cubes from a glass of water or other beverages and allow sufficient time for the temperature to rise before drinking the contents. Cooled drinks and not iced drinks taken slowly involve no risk.

In sharp contrast, the beneficial effects of hot drinks are worthy of mention. A hot drink taken by the patient before getting out of bed may save the morning. It imparts a feeling of warmth. In fact, hot drinks, such as warm milk for children and especially hot coffee for adults, tend to increase the body temperature. Protests greet the suggestion that a glass of hot water or a cup of coffee be taken soon after awakening. "I shall have to go and get it myself" is the usual plea.

(*Continued on page 603*)

THE CATHETERIZATION PROBLEM IN CONTINUOUS CAUDAL ANESTHESIA IN OBSTETRICS[*]

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HAVING used continuous caudal anesthesia in an active private practice of obstetrics from 1943 to 1951, and having been impressed with the frequent necessity for postpartum catheterization following delivery under caudal block anesthesia, I decided to make a study of this problem.

INNERVATION OF THE URINARY BLADDER

As stated by Bett,[1] the lower urinary tract nerve supply is widespread. The parasympathetics arise from the second and third sacral segments, the sympathetics from the second to the fourth lumbar segments. Surgical irritation of the sympathetics stimulates them to override the parasympathetic impulses, producing increased sphincter tension and a relaxed bladder, with retention resulting. Undue stretching of the bladder by overdistention may injure the neuromuscular mechanism of the organ to such an extent that recovery of its expulsive power may be difficult and prolonged.

Heimberger and Wilde[2] made accurate measurements of hypertonic bladders by novocaine blocks of the nerve roots in conjunction with cystometric studies. They found that the anterior root of the third sacral nerve is the dominant root supplying innervation to the human bladder.

Cleland[3] studied experimentally the innervation to the uterus. The sensory pathway from the uterus was followed through the fourth and third lumbar sympathetics and along the chain to the twelfth and eleventh thoracic roots via the rami communicantes. The sensory pathway from the birth canal was followed through the fourth and third sacral and second lumbar roots. Motor supply from the cord to the uterus was found to be extraordinarily wide, extending from the third thoracic to the second lumbar roots. The average level of the top of the eleventh thoracic skin segment must be anesthetized before complete relief of all pain in childbirth with caudal anesthesia is attained. This averages 1½ inches below the umbilicus.

Galley[4] found that the pain associated with uterine contractions is experienced via fibers which travel in juxtaposition with those of the sympathetic system to reach nerve roots of the eleventh and twelfth dorsal segments. Pain due to dilatation of the cervix uteri, the vagina and other soft parts of the birth canal is transmitted along fibers associated with the parasympathetic system and somatic nerves, all of which reach the cord via the second, third, and fourth sacral segments. Thus, nerve-block up to and including the eleventh dorsal segment eliminates all of the painful sensations associated with parturition.

From these studies it is obvious that the innervations to the bladder and to the uterus and the birth canal overlap and that the effect of continuous caudal anesthesia is felt by the bladder innervation as well as that of the uterus.

STATISTICAL DATA

Collins, Phillips and Oliver[5] made a statistical analysis of deliveries with continuous caudal anesthesia, done under the supervision of Hingson, Vaux and Lull at the Philadelphia Lying-in

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Unit of the Pennsylvania Hospital during the years 1943 to 1945. The records of deliveries during the years 1942 to 1943 at the same hospital provided a control group receiving good care by the usual methods of handling childbirth. Of the mothers in the caudal group, 16.7 per cent had 1 or more postpartum catheterizations, as compared with 14.1 per cent in the control group. However, 2.1 per cent of the mothers in the caudal group had 4 or more catheterizations, as compared with 2.4 per cent for the control group. The mean number for mothers with 1 or more catheterizations was 1.9 catheterizations in the caudal and 2.2 catheterizations in the control group.

Peacher and Robertson[6] report 2 cases demonstrating neurologic complications following the use of continuous caudal anesthesia. Their first patient had urinary retention requiring catheterization for several days. Cystoscopic and retrograde pyelogram studies showed no calculi or evidence of pathologic process except for elongation of the ureters with more pronounced distention of the left ureter than of the right. This roentgenographic evidence was consistent with the existence of a recent pregnancy but did not explain the urinary retention. In their second patient, drainage of the urinary bladder was necessary for 2 weeks because of urinary retention.

Andros and Henderson[7] reported their experience with 250 consecutive cases of continuous caudal anesthesia in obstetrics. Increased incidence of urinary retention was not noted in their series where distention of the bladder during labor was prevented by periodic catheterization. Their technic was to use an inlying catheter which was drained at least every hour.

A similar finding might be cited in the reports of urinary disturbance following spinal anesthesia. Davis[8] stated that the bladder musculature is completely blocked under spinal anesthesia and this fact may lead to trouble postoperatively. With muscular paralysis and loss of sensation the bladder may become overdistended and lose its tone. Cystometry following spinal anesthesia showed marked increase in bladder capacity. This combination of atony and loss of stimulus to void may lead to complications in the postoperative period, and the need of careful observation of the bladder and prophylactic catheterization has been emphasized.

Nicholson and Eversole[9] found that the cauda equina syndrome is one of the complications most frequently reported following spinal anesthesia. Loss of motor and sensory function is generally found to involve the lumbosacral nerve distribution. Associated observations are urinary retention and incontinence of feces with loss of anal sphincter tone. This loss of bowel and bladder function is the most ominous part of the entire clinical picture, and the return of function, when it occurs, is extremely slow.

Hebert, Tetirick and Ziemba[10] evaluated the complications encountered in 5,763 consecutive spinal anesthesias. Urinary retention of some degree occurred in 177 patients, an incidence of 3 per cent. In 25 cases, retention persisted 4 days or longer, requiring the use of an indwelling catheter. Two patients had residual symptoms 2 months after the operation and in 1 a cord bladder developed, which necessitated resection of the vesical neck.

RESULTS OF PRESENT STUDY

This study represents the routine deliveries in my private obstetrical service at Providence Hospital in Washington, D. C., during the 3 years, 1948, 1949 and 1950. During that time there were 1,080 deliveries, of which 302 were delivered under continuous caudal anesthesia. Of the deliveries under caudal block anesthesia there were 165 spontaneous, 115 low forceps, 19 manual rotation and low forceps, and 1 breech. In the group delivered under general anesthesia, consisting of ethylene oxygen with the addition of ether in a few cases, there were 471 spontaneous, 221 low forceps, 39 manual rotation and low forceps, 32 breech, 2 version and extraction, 1 mid forceps, and 14 cesarean sections. It has been generally thought that the use of continuous caudal anesthesia increases the incidence of persistent occiput posterior positions and also the incidence of the delivery by forceps as compared to delivery spontaneously. In this series, under caudal block anesthesia the percentage of forceps deliveries was 38.1 per cent as compared to 28.6 per cent in the 'non-caudal' group; the rotation and forceps deliveries were 6.2 per cent in the caudal as compared to 5.01 per cent in the 'non-caudal' group; and there were 54.6 per cent normal spontaneous deliveries among the caudal patients as compared to 60.5 per cent in the 'non-caudal.' These figures bear out the previous opinions, that the expulsive forces of the patient are less effective under caudal anesthesia and, therefore, the use of forceps is more frequently necessary; also, that the head rotates poorly in the caudal patient due to the relaxation of the pelvic floor, and manual or forceps rotation is more often needed. In this series all rotations were done manually and low forceps were used for delivery. The over-all incidence of cesarean section was 1.3 per cent, but none of the patients who were delivered by cesarean section had caudal anesthesia at any time in their labor. Caudal anesthesia was not given to any patient who gave a history of vaginal bleeding, and only 1 patient with breech presentation was given caudal anesthesia, and she had a severe upper respiratory infection. This patient was delivered by spontaneous breech extraction without untoward incident.

In addition to the 302 caudal anesthesias given there were 12 failures which were not included in the total number. Of the total number, 5 were poor, requiring the addition of general anesthesia, and 7 wore out in 3 to 8 hours after they were administered. These 7 also required general anesthesia for delivery. The average length of the caudal anesthesia was 2.9 hours.

The policy followed in patients in labor with continuous caudal anesthesia was to catheterize when the bladder distention indicated that it should be done. Catheterization before delivery was done more frequently in the patients under caudal anesthesia than in the 'non-caudal' group, due perhaps to the increased fluid intake involved in the injection of $1\frac{1}{2}$ per cent solution of metycaine into the caudal canal. This solution was used for all caudal anesthesia. The average volume for a single patient was 130 c.c. After delivery the patients were catheterized when the bladder level indicated that it was necessary, after every effort had been made to encourage the patient to void. Catheterizations were not done unless it was found absolutely necessary to do so, as it was felt that catheterization increased the incidence of bladder infection. Each patient who had any difficulty in voiding was encouraged to get out of bed and was taken to the bathroom to void. After catheterization was done repeatedly for 48 hours or more after delivery for urinary retention or for residual urine after voiding, a no. 18 Foley catheter was inserted into the bladder and allowed to remain in place for 24 hours. During this time the catheter was clamped off for 3 hours every 6 hours, thus permitting the bladder muscle to regain its tone. In only 1 instance was it necessary to re-insert the Foley catheter for a second 24-hour period, and this was in a 'non-caudal' patient.

Of the 1,080 patients delivered, 172 required catheterization. Of these 172 cases, 72 had had caudal anesthesia and 100 had had general anesthesia. Most of these patients who had had caudal anesthesia complained of the lack of desire to void and the lack of the feeling of bladder fullness. Straining sometimes brought a slight flow of urine but there was no normal urge to void until 3 or 4 days after the delivery. Of the 'caudal' patients 1 in 4.19 cases or 23.8 per cent required 1 or more catheterizations, and in the 'non-caudal' group, 1 in 10.8 or 9.2 per cent. Of those requiring the insertion of a Foley catheter, 1 in 50.3 or 1.98 per cent of the 'caudal' patients and 1 in 135 or 0.74 per cent of the 'non-caudal' patients was the incidence recorded. The average volume of urine obtained by catheterization was 721 c.c. There was no difference in the amount obtained from 'caudal' and 'non-caudal' patients, the judgment of the nurse in charge being used as the criterion for the proper time when catheterization should be done. The average number of catheterizations per patient in the 'caudal' group was 1.36, while the average in the 'non-caudal' group was 1.5, showing a slightly higher number per patient in the cases that were delivered under general anesthesia. This difference is not large enough to be of any significance, however.

Summary

It is concluded that the following observations hold true in the administration of caudal block anesthesia:

1. The neuromuscular mechanism of the urinary bladder is affected by continuous caudal anesthesia in such a way as to impair the expulsive power of the bladder.
2. There is a higher incidence of postpartum catheterization following delivery under continuous caudal anesthesia.
3. The urinary bladder should be catheterized at frequent intervals during labor under caudal anesthesia in order to prevent stretching the bladder by overdistention.
4. Postpartum catheterization should be carefully supervised and the bladder emptied when distention is not too great, in order to facilitate he return of bladder tone.

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BREECH PRESENTATION WITH HYPEREXTENSION OF THE NECK*†

Report of Three Cases

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THE increased hazard to the fetus in breech presentation, the incidence of which is about 4 per cent, is attested by the voluminous literature on the subject, wherein one finds mortality rates ranging from about 7 per cent for term infants to around 50 per cent for premature babies. Trauma during delivery is generally thought to be an important factor in maintaining mortality rates at these high levels. Prolapse of the cord or cord tight around the neck, premature separation of the placenta, cephalopelvic disproportion, incompletely dilated cervix, extension of the after-coming head, and congenital anomalies are among the causes of fetal death in breech presentation. It is the purpose of this paper to discuss another complication, an abnormality in fetal posture, namely, hyperextension of the neck, which may result in fetal injury during labor and delivery.

Two cases of this condition were encountered on the Obstetrical Service at Garfield Memorial Hospital, 1937–1939. Review of the literature at that time revealed reports of 2 similar cases, 1 by Laffont[1] (1918) and 1 by Garipuy[2] (1935). In 1936 Brakemann[3] in a radiological survey of fetal attitude in 191 cases of breech presentation reported as follows:

Attitude of Vertex	No. Cases	Percentage
Complete flexion	42	21.9
Neutral	116	60.7
Mild extension (sinciput)	12	6.2
Forehead extension	19	9.9
Face extension	2	1.0

Melody[4] (1948), Taylor[5] (1948), and Dougherty et al[6] (1953) each reported a single case of face hyperextension in breech presentation. In 1949 Wilcox[7] reported his investigation of the problem in 216 cases subjected to radiologic study out of the 1,918 breech presentations occurring at the New York Hospital, 1932 to 1947. He classified these 216 cases as follows: complete flexion, 86 or 39.8 per cent; neutral extension, 107 or 49.5 per cent; hyperextension, 23 or 10.7 per cent. Two of these cases were described in detail and were of sufficient extent to be classified as face hyperextension.

A recent case of my own, the third in my experience, renewed my interest in the problem and is included in this report.

Report of Cases

Case 1. Mrs. E. E., a 27-year-old white gravida i, was admitted to the hospital at term, August 16, 1937. Abdominal examination prior to her admission had revealed a term pregnancy with the head palpable in the upper right section of the fundus. The small parts and a flat surface interpreted to be the chest lay on the left with the breech palpable above the pelvic inlet. These findings were confirmed by X-ray examination (figure 1). With the patient under light anesthesia, the attending obstetrician was able to flex the head by appropriate abdominal pressure until the fetus had assumed an upright position (figure 2). Labor was induced medically. Progress was slow, and after 15 hours the patient's temperature and pulse began to rise. After 24 hours, irregularity of fetal heart evidenced fetal distress and made delivery necessary. Under ethylene anesthesia, dilatation of the cervix was completed manually, and a female infant weighing 6 lbs., 15 ozs. was delivered. The cord circled the neck once. No unusual hyperextension or stiffness of the neck was noticed. Mother and baby were discharged in good condition on the eleventh postpartum day.

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* From the Department of Obstetrics, Garfield Memorial Hospital, Washington, D. C.

† Presented at the Eastern Conference of Radiologists in Washington, D. C., March 12, 1954.

Case 2. Mrs. M. P., a 28-year-old white primipara, was admitted at term, November 6, 1938, 1½ hours after the onset of labor. Abdominal examination on admission revealed a term pregnancy with breech presenting. A hard, ballotable mass was felt in the right upper section of the fundus with a smooth rounded surface palpable at a slightly lower level on the other side. Small parts could be made out on the left. The cervix was undilated. The unusual attitude was confirmed on X-ray examination, which showed a breech presentation with the back and neck in such extreme hyperextension that the head almost rested on the buttocks (figure 3). Correction of the attitude was clearly impossible, and the infant was delivered without difficulty by cesarean section. Four loops of the cord were found drawn tightly around the baby's neck. The postpartum course was uneventful, and mother and infant were discharged in good condition on the eleventh day.

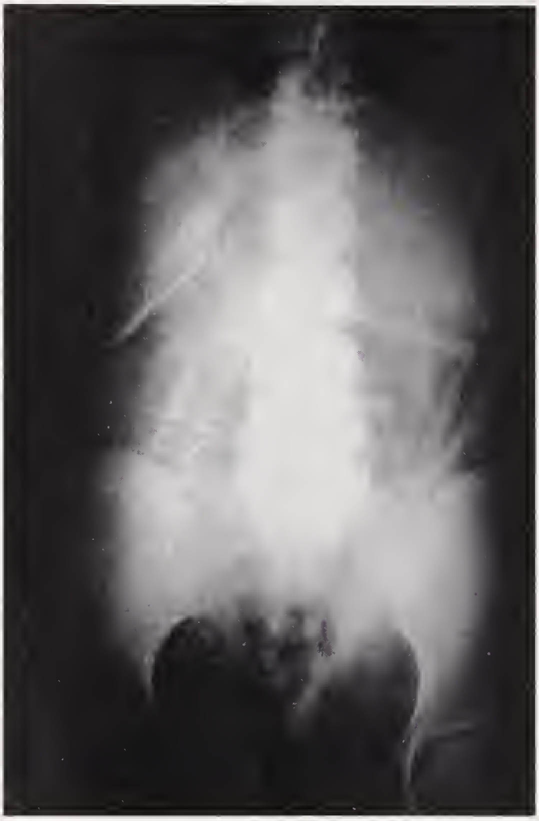

FIG. 1. Case 1, showing hyperextension of the fetal neck before correction by external manipulation.

Case 3. Mrs. J. M., a 30-year-old white gravida i, whose estimated date of delivery was November 7, 1953, was admitted in mild labor, November 11, 1953. X-ray examination prior to admission had revealed a term pregnancy lying in R.S.A. with the neck hyperextended so that with the mother standing the baby looked straight upward (figure 4). A well-developed, female infant weighing 5 lbs., 5 ozs. was delivered without difficulty by low, transverse cesarean section. At delivery the cord was found circling under the right axilla over the baby's forehead, holding the head in hyperextension. The pressure of the cord was sufficient to leave a temporary groove in the skin across the forehead. The head remained somewhat hyperextended for the first 24 hours. Mother and baby were discharged in good condition on the fifth postpartum day.

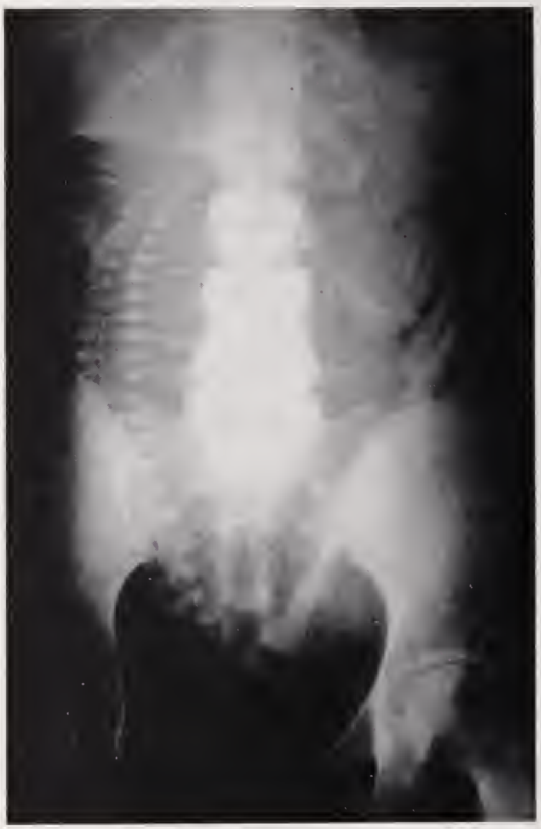

FIG. 2. Case 1 after correction of the position by flexion of the neck.

DISCUSSION

The incidence of hyperextension of the neck beyond the neutral position is difficult to estimate. However, it would appear that mild degrees of the condition are fairly common and probably frequently go unrecognized. Figures of Wilcox[7] and Brakemann[3] would indicate that between 10 and 15 per cent of breech presentations lie with the head between neutral and forehead extension. In probably about 1 per cent the condition is of such a degree as to be classified as face extension.

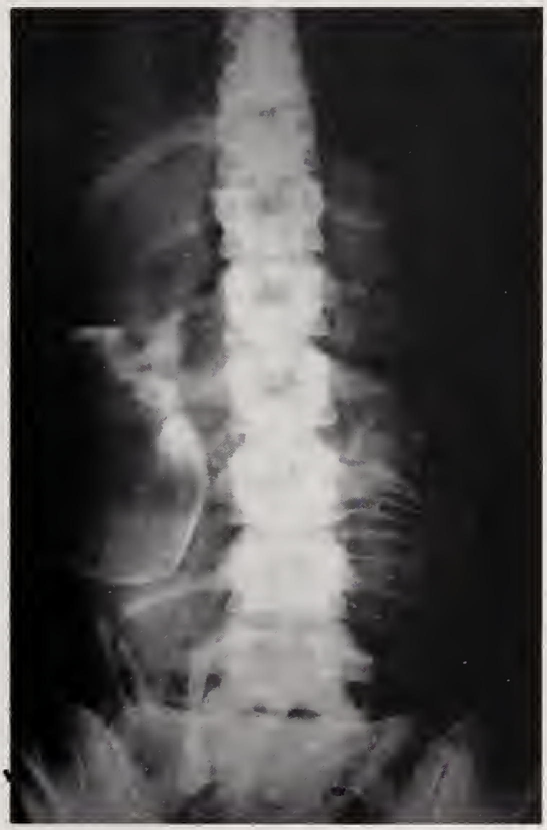

Fig. 3. Case 2, showing extreme hyperextension impossible to correct by external manipulation.

There may be a number of causes for the condition. Laffont[1] attributed the position in his case to dolichocephalus, and weight is added to his explanation by the fact that this abnormality was found also in the instance reported by Garipuy.[2] This, however, may be a result rather than the cause of the condition. Spasm of the fetal muscles, uterine or fetal anomalies, and uterine tumors are causes suggested by Dougherty.[6] It would appear from the cases reported here that a likely cause is tension of the cord falling in such a way as to draw the baby's head backward. This was undoubtedly the cause in 2 of these cases, 1 in which the cord circled the neck 4 times and 1 in which it was looped tightly under 1 arm and over the forehead.

The diagnosis is suggested in breech presentation when the fetal heart, transmitted through the chest rather than through the back, is heard on the same side on which the small parts are felt. The diagnosis is confirmed by X-ray examination and, inasmuch as the condition probably is frequently unrecognized, routine X-ray examination of all breech presentations would seem advisable.

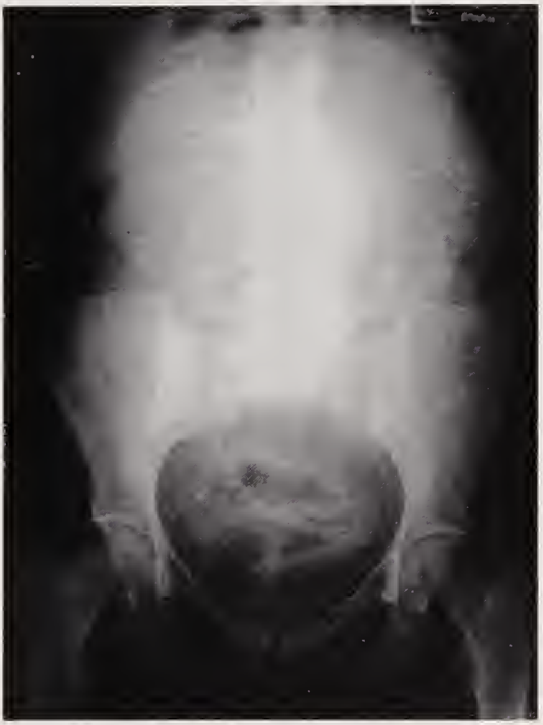

Fig. 4. Case 3.

The seriousness of the condition is shown by the results in the few cases of face hyperextension reported in detail in the literature. The infant delivered vaginally by Laffont[1] died in a few hours from a traumatic lesion with hemorrhage around the seventh cervical and first dorsal vertebrae with a laceration in the dura 2 cm. in length exposing the cord. The case reported by Taylor,[5] delivered by cesarean, suffered from intrauterine dislocation of the first, second and third cervical vertebrae on the fourth. The deformity was corrected by the application of a splint. In Melody's case[4] the baby was found to have bilateral posterior dislocations of the tibiae. One of the 2 cases of face hyperextension reported by Wilcox[7] was delivered vaginally. The infant showed signs of asphyxia and there was a tendency for the head to return to its fetal attitude after delivery. A cephalhematoma was noted, and later it was apparent that there was a transection of the cord at the first thoracic vertebra. In his second case a normal infant was delivered by cesarean section.

Treatment of the condition must be individualized. Mild extension of the neck may be corrected by external manipulation provided checking of the fetal heart shows no evidence of distress during the process. If a neutral position can be produced, labor may be allowed to proceed normally. If, however, the retroflexion is of such a degree that correction is not feasible, delivery by cesarean section is indicated.

SUMMARY

Three cases of breech presentation with hyperextension of the neck have been reported and the seriousness of this condition emphasized. The value of X-ray examination in the diagnosis has been stressed. Traction of the cord as an etiologic factor has been discussed. When correction of the malposition by external manipulation is not feasible, delivery by cesarean section is advised.

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SOLITARY DIVERTICULITIS OF THE CECUM AND OF THE TRANSVERSE COLON

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DIVERTICULITIS of the colon is a well recognized entity, and a voluminous literature exists regarding the diagnosis and management. In most instances multiple diverticula are present. Diverticulitis occurring in solitary diverticula is quite uncommon. Two such cases in our recent experience led us to focus attention on this condition.

Potier in 1912 described the first case of solitary diverticulitis of the cecum.[1] Sporadic case reports of solitary diverticulitis appeared in succeeding years. A review of the subject was made by Carroll,[1] who collected reports of 43 cases between 1912 and 1940, to which he added 1 case of his own. Fairbank and Rob[2] in England in 1947 were able to find reports of less than 60 cases in the American and British literature. In almost all of these cases the diverticula were located in the cecum or adjacent ascending colon. Isolated diverticula in the transverse colon are even more rare than in the cecum and ascending colon. Thompson and Fox[3] in 1944 reported a case of solitary diverticulum in the transverse colon. Lockhart-Mummery[4] in 1949 and Rowlands[5] in 1951 reported similar cases.

Pathogenesis and Morbid Anatomy

It is generally accepted that diverticula of the intestinal tract are of 2 types: true (congenital) diverticula, in which all layers of the bowel wall are present, and false (acquired), in which the muscle layers are absent, the wall of the diverticulum being composed of mucosa and muscularis mucosa. Several explanations of the formation of acquired diverticula have been advanced.[6] One group believes that ulceration of the mucosa of the cecum or colon progresses and ultimately leads to the formation of a false diverticulum. Inasmuch as a large percentage of these diverticula involve the cecum, increased intracecal pressure has been invoked as a possible causative factor.[7, 8] Abnormal tension on the cecal wall by adhesions following appendectomy has also been considered.[7, 9] Greenfelder and Hiller[9] mention 3 other possible mechanisms: eversion of the cecal wall between 2 constricting bands, eversion of a weak spot in the cecal wall caused by migration of a pursestring suture into the lumen of the intestine, and eversion of a weakened area in the cecal wall resulting from rupture of an appendiceal stump abscess into the cecum. Wilson[8] considers that an inherent weakness of the cecal wall due to age, congenital weakness, obesity or atrophy of fat along the vessels which penetrate the wall may play a role in producing such diverticula. Dorling[10] mentions that, since the diverticulum is a solitary one, the etiology may be different from that of multiple diverticulosis. However, impacted feces or fecaliths occur in about 75 per cent of cases of solitary diverticulitis, suggesting that the course of the pathologic process is quite similar to that of multiple diverticulosis.

Removal of the area of bowel containing the diverticulum has been the most frequent surgical procedure, thus affording opportunity to study the lesion. Acute inflammation is usual, together with evidence of previous inflammation. Perforation, with or without abscess formation, is common, frequently with the production of an inflammatory mass. Lymph nodes in the adjacent mesentery may be enlarged, often leading to suspicion of malignancy at the time of operation. These nodes are hyperplastic and inflamed. The bowel otherwise appears normal. Malignancy in such instances of solitary diverticula has not been reported. Microscopically, acute and chronic inflammatory changes are seen, often with necrosis in some areas.

Clinical Features

Solitary diverticulitis of the right colon usually simulates appendicitis, both with respect to recurrence of episodes and the acute attack. About 80 per cent of patients found to have solitary diverticulitis are operated on for appendicitis.[1] The condition is most common in adults, often under 40 years of age. It is rare in children. An antecedent history of recurrent episodes of right lower quadrant abdominal pain is frequent[1, 6, 7] but not of differential diagnostic value. An abrupt onset of abdominal pain, localizing to the right side with little or no fever, is a common clinical picture. Physical examination reveals right lower quadrant tenderness with some muscle guarding. A mass is palpable or suspected in about 50 per cent of cases.[1] Laboratory studies are not specific, the white blood cell count usually being elevated in the range of 10,000 to 20,000. As mentioned, appendicitis is the condition most frequently suspected. When a mass in the right lower quadrant is present, particularly in an older patient, neoplasm of the ascending colon may be considered. Other conditions to be considered in the differential diagnosis are tuberculosis of the cecum or terminal ileum and actinomycosis of the bowel.[8] Preoperative X-ray examination is seldom done, except possibly a plain film which characteristically is not helpful in establishing a diagnosis. The diagnosis is rarely established preoperatively.

Treatment

Early surgical intervention is the treatment of choice, and this is undoubtedly much to the patient's advantage since progression of the diverticulitis to perforation and abscess formation may be anticipated in a high percentage of cases.

Several procedures have been used in managing solitary diverticulitis of the cecum and ascending colon. In the cases reviewed by Carroll[1] the following procedures were done: excision of the diverticulum, 11; resection of the cecum, 12; resection of the cecum and ascending colon, 7; resection of the cecum and terminal ileum, 5; inversion of the diverticulum with purse-string suture, 3; drainage of the abscess, 3. The type of procedure is often decided by one of two factors: abscess formation or high suspicion of malignancy. In the former instance, drainage of the abscess is indicated. When there is suspicion of malignancy—and this may be enhanced by the presence of enlarged lymph nodes in the mesentery—some form of resection has been the procedure most frequently performed. Lockhart-Mummery,[4] however, reported a case in 1949, occurring in a 48-year-old woman, in which a Mikulicz type procedure was done in the belief that a malignant neoplasm was present. Later, when the lesion was defined as diverticulitis, the colostomy was closed.

Mortality in the reported cases of solitary diverticulitis is low, ranging from 4 to 6 per cent.[1, 6, 7] Several factors may contribute to this rather low mortality rate. The usual case presents itself as an acute episode for which early surgical intervention is indicated, which avoids severe toxicity or complications. In general, patients with solitary diverticulitis are younger adults (under 40), who are better risks surgically. The nature of the condition itself may be a factor, i.e., the tendency to localized abscess formation rather than widespread peritonitis. It is somewhat paradoxical, however, that in many instances resection of the involved bowel and primary anastomosis has been done without antibiotic preparation and yet relatively few complications have occurred. The use of antibiotics postoperatively has undoubtedly enhanced the use of good surgical technic.

Report of Cases

Case 1. A 42-year-old man was admitted with a history of persistent right lower quadrant abdominal pain of 1 day's duration. No nausea or vomiting occurred, and his appetite remained normal. Bowel movements had been normal. On the day of admission the patient became aware of a mass in the right lower quadrant. There was no antecedent history of similar episodes, and he had had no previous surgery.

On admission he did not appear acutely ill. His temperature was 100.2°F. Examination of the abdomen revealed acute, localized tenderness in the right lower quadrant. There was a mass measuring 3 by 3 cm. in that area which was movable and acutely tender. The white blood cell count was 20,350; a urinalysis was negative.

Operation was performed on the day of admission, with a McBurney type incision. An indurated, inflamed mass involving the cecum was present. This was grossly indistinguishable from a neoplasm. Several enlarged mesenteric nodes were noted. Resection was done, with removal of the terminal ileum, cecum and about 8 cm. of ascending colon. The severed ends of bowel were closed and a side-to-side ileocolostomy made. A drain was placed and the wound closed.

Postoperatively the patient had fever of 100.8°F. during the first 4 days. Antibiotic therapy with Aureomycin, 500 mg. intravenously for 2 doses, then Dicrysticin, twice daily for 5 days, was used. The drain was removed on the fourth day and the patient released from the hospital on the eighth day.

The surgical specimen revealed an inflamed diverticulum of the posterolateral aspect of the cecum, about 2.5 cm. in diameter. It contained a large fecalith. Microscopically, in the area of the diverticulum there was ulceration of the mucosal surface, acute inflammation, and an accumulation of necrotic material. The surrounding area of bowel wall was normal. The lymph nodes were markedly hyperplastic.

Case 2. A 34-year-old woman was admitted to the hospital because of abdominal pain of 18 hours' duration. She had been awakened by the pain, which was moderately severe and not localized. During the day the pain became more severe. It localized to the right lower quadrant after a substantial evening meal. There had been no nausea or vomiting. Two enemata during the course of the day were ineffectual. During her last pregnancy, which had terminated 3 months previously, a similar, less severe episode of right lower quadrant abdominal pain had occurred but had subsided promptly. She had not undergone surgery previously.

Examination revealed the patient to be mildly ill with a temperature of 100.6°F. and a pulse rate of 100 per minute. The abdomen was soft, with moderate, well localized tenderness in the right lower quadrant, accompanied by guarding and some rebound tenderness. A mass was not palpable. Pelvic and rectal examinations were negative. The white blood cell count was 17,250 with a normal differential count. A urinalysis was negative.

On the night of admission exploration through a McBurney incision revealed an abnormally large amount of thin, slightly cloudy fluid in the peritoneal cavity. The appendix, cecum and terminal ileum were normal. Inspection of the pelvic viscera revealed no abnormalities. The gallbladder was felt to be thin-walled and not distended, only the fundus being palpable. The liver edge was sharp. As the examining hand was withdrawn, a firm mass was felt, apparently in the transverse colon, near the hepatic flexure. Because of inability to discern the exact nature of the mass, the incision was enlarged obliquely upward. Examination revealed a firm mass situated in the transverse colon. A layer of fibrinous exudate covered its surface. A malignant neoplasm was suspected. An intestinal clamp was placed on either side of the involved segment, and an opening was made in the bowel along the taenia. Inspection of the lumen of the bowel revealed the orifice of a single diverticulum, from which exuded semi-solid fecal material. The area surrounding the diverticular orifice was inflamed and indurated. Resection of the segment of bowel was done and an end-to-end anastomosis made. The wound was closed, a Penrose drain being placed down to the peritoneum.

Postoperatively, Wangensteen suction was used for 24 hours, after which liquids were given orally. Terramycin, intravenously, was given twice daily for 2½ days, then orally (250 mg. q.i.d.) for 2 days. The patient was afebrile after the first day. She was given a soft diet after the third day. Bowel function was resumed normally on the fifth day. She was discharged on the seventh postoperative day.

Pathologic study of the surgical specimen showed acute inflammation of a solitary diverticulum measuring 3 by 2 cm., with impending perforation. Microscopically, the cavity of the diverticulum was seen to be filled with dense, necrotic, purulent material which extended to the serosal surface where surrounding fat was undergoing necrosis.

DISCUSSION

The unsuspected occurrence of a solitary diverticulum in the right side of the colon in these 2 cases is in accord with the experience of others. Because of a clinical picture strongly suggesting acute appendicitis, early surgical intervention was indicated in both instances. The formation of abscess in 1 case and impending perforation in the other made such management most fortuitous. In each case, too, strong suspicion of malignancy existed. The extensive involvement of the cecal area and adjacent lymph nodes in case 1 was strongly suggestive of a neoplasm with superimposed inflammation, making a right colectomy the procedure of election. In case 2 direct inspection of the interior of the involved area clarified the diagnosis. A segmental resection of this portion of the bowel was sufficient.

Although the incidence of solitary diverticulitis of the right half of the colon is low, it is apparent that one may encounter it quite unexpectedly. Further, the difficulty in differentiating this condition from a malignant neoplasm at operation makes it necessary in some instances to extend the operative procedure. Ideally, if one can feel reasonably certain of the diagnosis, resection of the involved portion of the bowel would suffice. However, the marked inflammatory reaction with actual or impending perforation and abscess formation are in favor of limiting the surgical procedure. It is worthy of emphasis that, if one cannot exclude the diagnosis of a malignant lesion, the case should be treated as if it were one. Compromise of surgical procedure is not justified. The use of careful surgical technic supplemented by postoperative antibiotic therapy should counteract difficulties anticipated as a result of inability to utilize customary preoperative measures.

SUMMARY

The historical, clinical and pathologic aspects of solitary diverticula occurring in the right side of the colon have been reviewed.

Two cases are presented which illustrate the unexpected occurrence of this condition, usually in a patient suspected of having acute appendicitis.

Because of the frequent inability to exclude a malignant neoplasm at operation, radical resection of the right half of the colon may be necessary (case 1).

Local resection of the involved segment of bowel will suffice if the diagnosis can be established and abscess formation does not preclude definitive surgery (case 2).

Particular attention to technic and postoperative antibiotic therapy are effective in achieving a good result in patients unprepared for such bowel surgery.

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THE NEUROSES FOLLOWING TRAUMA[*]

Part II

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THE work of many authorities has contributed to our understanding of the neuroses following trauma. Oppenheimer's theory of actual "molecular change" in the nervous system as a physical consequence to the traumatic event was early discarded, as the psychogenic basis of symptom-formation became more recognized. In a paper on Charcot, Freud[17] reported in 1893 how this famous early French neurologist had "successfully presented the case for hysteria" from his and his pupils' "research work concerning the nervous diseases following upon traumas—the traumatic neuroses." Freud[18] soon compared the initiating experience in traumatic neurosis with that of hysteria. He noted also that "In traumatic neurosis the active cause of illness is not the trifling bodily injury but the effect of fright—the psychic trauma." In essence this conforms to our clinical observations; i.e., there is often no apparent correlation between the seriousness of injury and the extent of the symptomatology which may develop. It is the hidden meaning and the individual significance of what has happened which is important. Thus the outwardly minor trauma, as seen by an objective observer, may actually be of much more serious import than it may appear.

The neurotic illnesses following trauma are also more or less clearly regressive in character.[19] Feelings of impotence and helplessness contribute to the impact of the traumatic event as can unpreparedness or unexpectedness, exhaustion, the fatigue from chronic stress, etc. The repressive nature of the symptoms as a consequence to external stress may be often observed through their implicit dependent appeal. In essence the ego has received a desperate blow in its attempt to cope with the environment, and a retreat ensues to a more comfortable antecedent stage. As Fenichel[20] described it, there is "a regression to the more primitive passive-receptive type of mastery of the outside world following their failure to succeed in an active way." Similarly, in discussing traumatic symptoms and disturbances, Alexander[21] wrote, "All these reactions can be explained as signs of damage to the ego, which, under the intimidating influence of the trauma, abandons its mastery of coordination and regressively retreats to helplessness."

I have earlier referred to the "favorable, psychologic soil," the "conditioning" process which results in the predisposition of the individual to the development of neurotic symptoms. This predisposition, which already exists at the time of trauma, is seldom very readily observable. It has also already been illustrated that the actual traumatic situation as observed objectively can vary from minimal, as illustrated in case 1, to maximal, as illustrated in case 2. In general, traumatic experiences are a regular and inevitable consequence to living, in which a factor of major importance is one's relative ability to cope with them. This is the function which one hopes will be adequately served by the individual E.P.R.T.—the emotional-physiologic response to trauma. From this line of thinking, neurosis following trauma may then be regarded as a consequence to the failure of the defensive and protective forces of the ego. Stern[22] offered a similar opinion when he stated that "Neurosis is not the effect of trauma but the result of a specific failure of the defense against traumata which are normal occurrences in the life of any individual."

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This is Part II of the final article in a series by Dr. Laughlin covering the psychoneuroses, which began in the August, 1953 issue of the MEDICAL ANNALS.

This entire series will be revised and included with selected additional material in a forthcoming psychiatric text by Dr. Laughlin, entitled "Understanding the Neuroses," and scheduled for publication early in 1955 by W. B. Saunders Co., Philadelphia, Pa.

A principal distinguishing feature of certain kinds of the traumatic neuroses from other neuroses is the sharpness of the precipitating event. Grinker and Spiegel[23] regard traumatic neuroses as similar to all other neuroses. In the traumatic neurosis there is a fusion of preexisting emotional conflicts with the acute reaction. At one point Fenichel[24] writes of the artificial distinction between traumatic neurosis and the psychoneuroses. Alexander[21] reports that "what characterizes the group called 'traumatic neuroses' is not the trauma, which is present in every neurosis, but the acuteness of the condition." Smith and Solomon[25] in their treatise on "Traumatic Neuroses in Court" colorfully write that "traumatic neurosis is the flowering stalk of a previously planted seed, the recurrent breaking open of an old scar. . . ."

Some of these concepts in the psychogenesis of the neuroses following trauma may become clearer through the following illustration:

Case 8. *The onset of a severe neurosis following a psychologically traumatic event.* A 33-year-old associate professor of mathematics was referred for analysis several months after the onset of a very severe neurosis. The manifestations were principally those of anxiety and depression with some obsessive-hypochondriacal preoccupation. At the time of the first consultation he was tortured by nervousness, insomnia, recurrent disturbing dreams, and strong feelings of guilt and self-blame accompanied by nearly constant weeping and an unhealthy, obsessional kind of religiosity. Prior to referral he had been studied and treated with little success under a medical regimen which was carried many weeks past any optimal point of study (and long past a medical conclusion of essentially negative organic findings) largely because of his own insistence.

The onset of symptoms occurred abruptly following his father's sudden death. This tragic event had transpired less than an hour after an angry scene between the patient and his father. The patient held himself responsible for his father's death. He felt unworthy and sinful. He felt certain of death from an impending heart attack, described severe chest pains and difficulty in breathing, and announced his belief that God was causing him this discomfort and suffering as punishment for his sin. He was so emotionally distressed that he could give little information. Here then, on the face of it, is a rather simple example of neurosis following trauma. However, if one hopes to therapeutically influence the neurotic process, to uncover and resolve possible hidden conflicts, this is barely even a point of beginning. As Trawick and Bate[26] pointed out, ". . . study is necessary if we are to establish a specific relationship of the psychic situation to the personality of the individual. Just as the typhoid bacillus, specific for typhoid fever, depends upon the susceptibility of the individual, so does specificity of the psychic event depend upon the personality structure of the person." For the traumatic event to have its precipitating and often devastating effect, it very often has a special significance, an individual specificity.

The father had been a successful rancher who had steadily increased his acreage while raising a large family. Things had gone increasingly poorly, however, in recent years. The father's capacity to work had decreased and his business judgment had deteriorated under the joint onslaughts of age and arteriosclerosis. There was also decreased appreciation of social mores involving embarrassing incidents of unwelcome sexual advances toward young women acquaintances of the family. He had already sold off half of his ranch holdings and was in the process of disposing of another large portion of the shrinking balance, to the great concern of his wife and children. He suffered also from chronic heart failure with repeated attacks, from several of which recently he had not been expected to live. In this setting the patient had made the visit to his Texas ranch home. This is the most apparent part of the objective situation in which he angrily upbraided his father for depleting the family security. While one, of course, cannot rule out the angry outburst as being a possible factor in the father's death at this time, it is a far cry from the total degree of guilt and responsibility assumed in neurotic fashion by the patient.

In these circumstances why is the consequence of the father's death the onset of so devastating a neurosis as to effectively cripple the patient's capacity for living?

Prolonged work in treatment provided many of the answers.

The patient had been an underdeveloped, malnourished, and sickly child. Partly as a result and because he was also a younger child he was overprotected. Decisions were made for him which helped to create a passive, dependent role into which he readily fit himself. At the same time he sympathetically identified with his mother, who "took many things from Dad she should never have had to." His closeness to his mother became part of an intense dependence which was reflected in repetitive fashion in his own later choice of a wife and his relationship with her. Part of the picture was also a tremendous protective overcontrol of hostility. Characterologically, he became a mild-mannered person who almost never outwardly expressed disagreement or difference of opinion. The degree of his restrictions and his fear of his feelings in this regard is perhaps illustrated by his reaction in college when one of a pair of classmates was killed in an auto accident following an angry, rebellious outburst by them toward the dean and their subsequent defiance of college rules. His reaction was a vicarious identification with the rebels. He became so distressed that his ordinarily excellent grades dropped, somatic complaints developed, and he very nearly had to drop out of school completely.

This patient's choice of occupation also tied in with his inner needs. Research in mathematics and teaching were for him a passive and dependent way of adaptation, a more abstract, detached, and therefore safer life. His outburst toward father was unprecedented. It took place only after years of storing up resentment until finally the "warehouse" was bursting. In partial stringent summary, his worst hidden fears of the destructive potential of his own anger were realized. How frighteningly potent his anger really was when allowed expression! The results approximate his own long-buried infantile apprehensions. In consequence he holds himself totally, albeit unrealistically responsible. The hypochondriasis was part of an attempted neurotic regressive retreat toward an earlier, even more dependent position. The depth of the illness in this case bordered on the psychotic in several areas.

In this case there was a definite trauma. While undoubtedly this would prove distressing in varying degree to anyone, it became such a crushing blow to this patient as to threaten his very existence. We see that his entire character structure and past existence were so constituted as to multiply infinitely the effects of the psychologically traumatic event which served to precipitate the development of his neurosis.

This brings us to another important factor sometimes observed in neurosis generally, i.e., the need to suffer, to be punished. Accordingly, there may often be greater suffering in the absence of physical or functional handicap or loss. The latter when present often appears to satisfy the hidden demands of a sometimes hypertrophied and often archaic superego. This helps account for the failure of the symptoms which develop to proportionately reflect the degree of the real physical injury following trauma. As we have earlier noted, the symptomatology and the distress manifested psychologically are often greater when the trauma is actually slight, or at least where the outward physical consequences are slight.

A variation of this is observed, for example, among seriously wounded patients in wartime who more rarely show the intense emotional disturbances seen in some of their unwounded comrades. Instances have also been seen in which a psychotic episode undergoes remission, or a neurotic illness improves following surgery, an accident, intercurrent illness, or an injury. The success of shock treatment has been explained by some authors on the basis of gratification of unconscious needs for punishment.* When these needs are strongly operative and physical injury or suffering is minimal, they remain unsatisfied or may be only partly satisfied. It is as though the resulting emotional suffering, deprivation and loss sometimes attempt then to satisfy them in substitute fashion. Similarly, Dr. Edith Weigert† writes, "We observe in traumatic neuroses the greater severity of psychological symptomatology when no organic damage has occurred. Organic damage seems to alleviate anxiety and its defensive derivatives."

Fenichel[21] contrasted the emotional situation in a number of other neuroses where there is "too little discharge" with that of traumatic neuroses where there is "too much influx." Glover[28] pointed out certain "screening functions" of the memories of traumatic events. In Part I we saw that symptoms in emotional illness serve various hidden purposes. These include the epigain (the unconscious secondary gain) as well as the endogain or primary gain of the emotional illness. It should be noted that this principle applies in the way the patient perceives the trauma. Thus, not uncommonly, there is hidden and symbolic significance here; e.g., the trauma may be "perceived" unconsciously as having deeply buried elements of symbolic temptation—satisfaction or gratification on the one hand, and of retribution or punishment on the other.

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* In reference to this point, Weigert[27] concluded that "Shock and convulsive therapy is opposed to the main striving of psychoanalytic therapy: to mitigate the cruelty of an archaic superego and to help the patient to endure the necessary, but not the unnecessary hardships of reality."

† Personal communication, June 28, 1954.

In these brief remarks on dynamics it should be noted that the field of psychopathology represented here is so broad that it can involve factors considered in our earlier discussions of each type of neurosis. Schilder,[11] in discussing neuroses following head traumata, cited 3 important components: (1) a threat to integrity (death or deformity), (2) a superior force, and (3) a masochistic gratification. In closing, I would add the thought that depending upon many complex factors, the traumatic experiences of infancy and early childhood may serve to sensitize or to desensitize the individual and his reaction to traumatic experiences in later life. Thus, his ability to tolerate and to cope with subsequent traumatic events is influenced by his earlier conditioning. The individual's emotional-physiologic response to trauma, his E.P.R.T., is his assembled potential of personal resources; his strengths and weaknesses as present constitutionally and as modified and influenced by experiences and the vicissitudes of living.

SOME CLINICAL FEATURES

The symptoms which may be seen in the neuroses having their onset following trauma are legion. Nervousness, restlessness, tension, insomnia, and the rather direct manifestations of anxiety are common. However, hysterical phenomena,* somatization reactions, and physical or functional limitations are seen in which little overt evidence of anxiety is manifest. In these situations it is bound or converted into more devious forms. Diminished sexual interest and impaired function are frequent. At times a dissociative reaction may occur. Fainting is a kind of primitive total response aimed at excluding the traumatic stimulus by cutting off perception. Amnesia and rarely a fugue state may be seen. Elements of depression and its close relative, emotional fatigue, may be seen not infrequently. The following case is an example of a rather rare kind of dissociative, fugue-like state which can occasionally follow an emotionally traumatic event:

Case 9. *A brief dissociative state following a traumatic event.* I had read the newspaper account of the sad instance in which 2 brothers had gone swimming and gotten into trouble in the water. The elder brother had made it to shore with some assistance. The younger brother had drowned. I had wondered at the time about the possible traumatic effects of such a tragedy upon the survivor, not knowing then that I was soon to see him professionally. The body was soon recovered. The surviving brother visited the funeral parlor to view the body. At this time he went into an overactive, fugue-like, dissociative state. He was partially irrational, moving restlessly and aimlessly about at a pace varying from moderate to frenzied. There were also hysterical elements in the over-all response. He remained quite suggestible despite his wild behavior. His activity increased markedly whenever relatives happened to be present. He was given a massive amount of sedation before the desired calming effect on his activity was secured. He was then admitted to a general hospital where he was seen in consultation.

Some 36 hours later he had calmed down substantially and it soon became possible to secure a fairly adequate history. The brothers had actually struggled together in the water for survival. One can readily appreciate some of the terrible conflicts activated by such a desperate situation and its tragic finale. The survivor suffered unbearable self-doubts, guilt, and recriminations. These were reactivations of the inevitable antecedent conflicts over sibling rivalry and competitiveness.

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* Dr. Lawrence C. Kolb, in discussing hysterical reactions, reports an observation concerning their possible relationship to schizophrenia and certain necessary precautions. He writes, "A number of individuals have come to us with a hysterical symptom screening a basic schizophrenic process. The attempt to suddenly reduce the symptoms in these circumstances may precipitate an overt schizophrenic reaction." (Personal communication, July 9, 1954.)

His route of escape from the intolerable emotions had been a psychologic flight into the dissociative state. The fugue state was of brief duration in this instance, largely because he had previously been a rather well-adjusted person with a number of rather effective hysterical character defenses. He was a person of rather limited imagination and intellectual resources. He was able to reintegrate his defenses rather quickly with some slight assistance from therapeutic efforts. These defenses consisted largely of denial and the assignment of responsibility to fate. While on a rather primitive level, their operation was most effective. The patient was actually able to attend his brother's funeral without further apparent untoward effects. He had suffered an acute but short-lived dissociative state, effected some rapid psychologic adjustments, however primitive, and was soon able to carry on with no outwardly apparent ill-effects. One may of course indulge in some speculation about the possible future significances or effects of such a soul-shaking experience.

One rather characteristic feature in the acute type of post-traumatic emotional illness is the repetitive dream. We have seen this illustrated in several instances. In combat situations as in acute civilian traumata the dream appears to serve a desensitization kind of purpose and to modify the actual events rather magically to make them less traumatic. From this standpoint I sometimes regard this kind of disturbing dream as a kind of subconscious abreaction. Loewenstein[29] interestingly analyzed a post-traumatic dream which followed a dramatic canoe upset and nearly-miraculous subsequent rescue after traversing some very dangerous rapids. Herein the traumatic event was repeated but not exactly reproduced. Distortions served to conceal and to hide the original trauma, to fulfill wishes, and to master what had been threatening reality.

Large elements of epigain, the unconscious secondary gain of the illness, frequently complicate the picture and darken the prognosis of emotional illnesses following physical trauma. The symptoms which are seen also often convey the implicit underlying helplessness and the dependent appeal. A volume might be written alone on the many complex problems and the important psychologic considerations incident to the granting or seeking of compensation and pensions in civilian accidents and in certain industrial and military cases. The importance assigned by some authorities to this aspect of the problem is reflected in their use at times of the term "compensation neuroses." To my mind it overemphasizes one unfortunate aspect of a most complex illness in a way that hardly invites further efforts at study, treatment, or sympathetic medical understanding.

COMBAT EXHAUSTION AND THE EMOTIONAL REACTIONS INCIDENT TO MILITARY OPERATIONS

Herein are included the emotional reactions incident to the rather special stresses of combat and war. Such cases have at times carried a variety of diagnostic labels, for example, as follows:

1. Acute situational reaction
2. Acute situational stress
3. Anxiety neurosis
4. Anxiety state
5. Blast or concussion syndrome
6. Combat exhaustion
7. Combat fatigue
8. Gross stress reaction*
9. Operational fatigue
10. Operational stress
11. Psychoneuroses of various kinds
12. Shell shock
13. Traumatic hysteria
14. Traumatic neurosis
15. War neurosis

This partly reflects various professional views and the development of theory, as well as accumulated experience (table 1). There has also been present the desire in some quarters to consider separately these reactions from neuroses per se, because of the special circumstances of onset following military stress and because of past lay and professional prejudices in regard to neuroses. Space will unfortunately permit only the listing of symptoms and a few remarks concerning this interesting and important subject. Bibliographic references cited will lead the student into additional sources.

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* Currently official, A.P.A.-A.M.A. classification (000 × 81).

TABLE 1

The Diagnoses Given Combat Reactions

Monthly Admissions by Diagnosis to an Active Ward in a Service Treatment Hospital in World War II during 1945

Diagnosis	Number of Admissions											
	Jan.	Feb.	Mar.	Apr.	May*	June	July	Aug.	Sept.†	Oct.	Nov.	Dec.
Combat fatigue	10	9	8	27	25	18	15	16	10	8	2	1
Psychoneurosis, Anxiety	4	4	7	4	16	7	11	16	19	19	9	4
Operational fatigue	16	23	18	2	10	7	11	10	9	13	20	14
War neurosis	2	1	2	2	1	—	—	—	—	—	—	—
Other (miscellaneous)	2	1	2	5	5	3	2	2	2	5	5	6

* VE-Day (May 8)

† VJ-Day (Sept. 2)

The manifestations of "combat reactions" are those of anxiety, expressed directly or indirectly, or the effects of anxiety. In over three quarters of one group of 100 consecutive acute cases (seen within 30 to 60 days or less following the initiating combat experience) anxiety and tension were readily apparent. Half showed tremors which varied from mild finger tremors to gross bodily shaking. Nearly half were restless. About half suffered from a considerable degree of insomnia, while at least one fourth complained strongly of their repetitive disturbing nightmares and battle dreams. A "startle reaction" to sudden noises was still marked in at least 20 per cent, while nearly a similar number complained of interference with mental function. A substantial number exhibited somatization conversions of various kinds, and a smaller group showed depression, emotional fatigue, weakness, or seclusiveness. A tabulation of the clinical manifestations of this group of patients follows in table 2.

Among the manifestations of acute combat reactions the outstanding, of course, is usually the tremendous amount of anxiety which is mobilized and which is often outwardly apparent.

TABLE 2

The Symptoms of Combat Reactions

A review of the clinical summaries of 100 consecutive cases of acute emotional disturbances following combat in World War II shows the frequency of their major difficulties, as follows:

A. Direct Anxiety:	
1. Reported simply as "nervousness"	77
2. Anxiety (subjective or observed)	73
3. Tension	57
B. Psychomotor:	
1. Tremors, to gross shaking	50
2. Sleep disturbances:	
a. Marked insomnia	50
b. Nightmares and battle dreams	25
3. Restlessness	42
4. Startle reaction	19
5. Speech difficulties	6
C. Mental (including disturbances in concentration and attention, confusion, and 2 cases with amnesic episodes)	16
D. Somatization Conversions:	
1. Headache	27
2. Backache, leg pains	6
3. Hyperhydrosis	13
4. Cardiovascular symptoms	4
5. Gastrointestinal symptoms (anorexia, 34; nausea, 3; major weight loss, 5)	9
6. Genitourinary symptoms	2
E. Psychologic Conversions:	
1. Emotional fatigue and weakness	20
2. Depression and guilt	18
3. Withdrawal, seclusion, and apathy	12
4. Irritability	35

As seen in World War II, there were also 4 features which tended to be characteristic in many cases. They are (1) the startle reaction, (2) the repetitive battle dreams, (3) the irritability, and (4) the occasional gross tremors.

The "startle reaction" is best understood on the basis of conditioning to danger. In battle, immediate (i.e., reflex) physical reaction is vital to survival. The soldier becomes conditioned to so respond. It is part of his E.P.R.C. (emotional-physiologic reaction to crisis) which has seen further development during training. It becomes so firmly established, usually under combat conditions, that it continues past the time and situation when sudden noises or movements actually carry a high probability of personal danger to him. A sudden noise produces instant mobilization for flight or fight. Sometimes this is overdone and the resulting reaction may be actually inappropriate in extent or time. The "startle reaction" especially following removal from the actual danger zone is an example. It should also be noted that the large potential of energy made available in such, no longer appropriate, fashion can quickly change into an angry-hostile swinging fisticuff assault on occasion. This has happened, for example, when someone purposely elicits this reaction as an ill-begotten attempt at humor.

Repetitive dreams of combat appear to serve a protective function through abreaction, desensitization, and a more or less symbolic reassertion of mastery over the terribly threatening environment. They can obviously be terrifying experiences in themselves, and it is not uncommon to have a soldier fear to go to sleep because of them.

The irritability is at times a more complex manifestation. Frequently included are elements of resentment toward authority, a response to projected self-disapproval and guilt which may or may not be realistic, and a transition into angry-hostile feelings of the continued anxiety-tension potential. The irritability and its expression can at times also have an aspect of almost openly seeking retaliatory restriction or punishment. This is particularly true when present in a military situation, and it is an aspect which must be recognized in the adequate handling of the many disciplinary problems which are apt to arise in this group of patients. Saul[30] discusses "provocativeness" as a symptom, which acts as a defense against expression of aggressive feelings by the person behaving in such a way as to invite punishment. Obviously such reactions often bear the closest relationship to antecedent conflicts of an interpersonal nature from early life which in effect may be reactivated by the stress of combat. The gross shaking (as the restlessness) is the partial translation into nonconstructive bodily expression of the undischarged energy potential. Hyperhydrosis can be marked. I have seen cases in which palmar sweating is so great that drops of sweat fall steadily from every finger, soon forming a small puddle. These very acute reactions generally slowly subside following removal from the danger situation. Resolution of the symptoms can be speeded up considerably by judicious management and by kindly, sympathetic and understanding therapy, even on a fairly superficial level. Group therapy can be especially helpful at times in view of the similarity of experiences and symptoms and the scarcity of skilled professional help.

War and combat neuroses demonstrate the vital role of self-preservation in individual psychology. Relative individual susceptibility is based upon many factors including:

1. The basic stability and adjustment
2. The sensitization or desensitization effects of prior trauma
3. The adequacy of defenses mobilized and developed during training
4. The level of morale and the effectiveness of unit or group identification[31]
5. Subjective feelings of relative impotence, vulnerability, and omnipotence
6. The tactical and strategic position (e.g., a retreating or defeated army has a much tougher job maintaining morale)

7. The presence of fatigue, sleeplessness, and exhaustion; the weakening of defenses through repeated exposure to trauma and chronic stress.

Zabriskie and Bush[32] describe war neurosis as the outcome of a conflict between fear and the urge to flee and a sense of duty. Sperling[33] summarizes, "War neuroses and civilian traumatic neuroses are based on the conflict between love and hatred transferred from the oedipus complex to society (the country) as a whole." He also states that "War neurosis is based on a conflict between love for, and hatred of one's country. Trauma is one of several factors that mobilize the hatred." In many instances I suspect that the dynamics of individual cases are more complex. Several years of my military experience during World War II were devoted exclusively to the management and treatment of acute emotional casualties following combat. Since 1947 I have served regularly as a civilian consultant to the U.S. Army Surgeon General, teaching and supervising the work of psychiatric residents-in-training at the Army Medical Center, where I have had contact with many additional cases including combat evacuees from Korea. Among the hundreds of patients I have worked with or had contact with, I would not attempt to simply categorize the dynamics in very many instances. Although patients seen often have many common features, the management and understanding of each is a very individual matter.

In reviewing the literature I am impressed with apparent differences in the symptoms between the cases as described clinically in World War I and those of my own and others' experiences in World War II. Ferenczi,[34] for example, in describing cases in the earlier conflict, reports many gross disorders of movement and serious degrees of handicap, contractures, spasticities, etc. Many of these reactions were akin to gross conversion hysterias and have been much less frequently seen in World War II. Simmel[35] in an interesting discussion of his experience and theory stresses the importance of the accumulation of traumatic influences in the onset of war neuroses. Kardiner[36] differentiated traumatic reactions from other forms of psychoneuroses. Dreyfuss[37] regarded the shock itself as a "screen" experience. One might write volumes on this fascinating subject alone,[23, 38] but limitations of time and space prevent other than the inclusion of these few selected comments.

THE PSYCHOLOGIC PROCESSING OR CONDITIONING OF PRISONERS (BRAIN WASHING)

During the last several decades a method has been evolved to secure greater influence and control over prisoners and their behavior than has heretofore been generally considered possible. Termed "brain washing" by popular usage, it has at the same time proved intriguing and seemed mysterious, as a result of which its results have been regarded with great skepticism by many. Actually there is little mystery when one studies the methods used. These methods represent a considerable modern psychologic refinement and are much more subtle than the cruder approaches of physical torture of centuries past.

The conditioning of prisoners as developed in the Soviet world is a traumatically induced form of personality alteration and control. It involves the application of some of the most modern theories and knowledge to produce maximum psychologic stress and emotional pressure in sufficient force and over a sufficiently prolonged period to result in the moulding of a prisoner's attitudes and behavior to the desired ends of the operators. Brain washing constitutes a destructive assault upon human personality and integrity of an unbelievable level of cruelty. Through its use in the more noteworthy individual instances selected, unparalleled control has been secured over political and military victims.

The development of this perverse science gives new weight in savage form to the conditioned reflex theories of Pavlov. The controlling of people, the securing of confessions, the powerfully puppeteered court behavior of accused prisoners, all have borne tragic witness to the effectiveness of this kind of human conditioning in expert hands. A number of accounts[39, 40, 41] offer more of the details of how these results are achieved. Brain washing provides a pointed example of the tremendous effects which can be wrought on the stability, the adjustment, and the personal integrity of the person of high moral fiber through psychologic trauma—in these instances deliberately cultivated and applied. Physical torture has in turn been reserved for the less well educated and cultured person who is lacking in development of high ethical standards and moral fiber. For the former, methods of physical torture were too crude and often resulted in death. Accordingly, "brain washing" was developed.

It might be noted that these changes are not brought about readily. From the study of the more noteworthy cases (e.g., Cardinal Mindszenty, Michael Shipkov, Hans Fritzsche, Robert Vogeler, William Oatis, and others) we learn of the many months of time and effort which were exerted by the most skilled operators working in shifts in the "processing" of these unfortunate victims. In the case of Shipkov a complete detailed "confession" was secured in 32 hours, which was, however, later repudiated. Cardinal Mindszenty withstood 3 days and 2 nights of steady, ceaseless pounding, interrogation, suggestion, and demands before he made his first capitulation; months of steady psychologic battering by the most skilled operators before he was moulded to their will. For brain washing to have its strongest effects, it must be applied individually, yet where the political gain is sufficient to justify employment of the requisite effort and time of the most skilled operators, it is highly doubtful whether anyone can fail to become an abject victim.

Eventually the person will be willing to say, to write, to do anything that his inquisitors request. Eventually he will want to give anything or do anything to satisfy the demands of his tormentors. His need is to secure peace and respite. He becomes actually anxious to begin whatever punishment which he feels may be meted out, and even to die if this is to be his fate. The wish for death as a way to peace or escape is not an unusual expressed wish by the victim as the ceaseless interrogating and demanding efforts continue.

Complete isolation, the feeling of abandonment, and the impotence of anyone to help are strong factors. Threats to relatives, friends, associates or colleagues are meted out whenever it is felt that they will help. This is usually done in an atmosphere in which the victim has few doubts that the threats could and would be carried through.

Part of the skill of the "professional" interrogator in the field comes from the fine judgment which he is able to exercise on the basis of experience and training as to just how far and and to what given point he can push his victim. In order to achieve success, of course, he must be able to anticipate correctly the breaking point and ease pressure sufficiently to avert a psychosis or death.

In general, the amount of time and effort required to secure the desired degree of control and behavior in the conditioning of prisoners will depend on a number of variable factors as tabulated below:

A. The previous emotional and mental conditioning of the prisoner

B. His total psychologic and personality integration (this is most important)

C. The treatment, mistreatment, or threats to members of the patient's family or friends (and the potential ability to carry them out)

D. The determination and morale of the prisoner

E. The determination, persistence, skill, and experience of the "examiner" or "interrogator"

F. The urgency of the need to secure results. It is possible that slower methods of wearing down a person's resistance are more effective in certain individual cases. These might become a requirement because of unusual stubbornness or resistance on the part of the prisoner.

In general, the prisoner's educational, social, ethical, economic, and class background, as well as his moral stamina, patriotism, existing loyalties, and personality stability are all very important factors.

Let us consider very briefly how a person of high integrity and considerable moral fiber can be brought to apparently sincerely "confess" to things he could not possibly have done. In the first stage, the hapless and helpless victim is constantly bombarded by interrogation, with no rest, with limited food, and with no water. An endless assault is maintained, with ceaseless battering psychologically. The patient's will to resist is slowly beaten down. The burden of fatigue and sleep-loss are added. Threats, demands, alternate promises of better treatment, and hope for surcease continue. A detailed autobiography is secured.

Gradually the victim is worn down. After 66 hours Cardinal Mindszenty was reported to have said, "End it all. Kill me. I am ready to die!"[39] The reply to this was simple; he was told in effect, "You can end it all by answering certain questions in the way we wish you to." As the wearing down process continues, the desire to please one's tormentors and interrogators by any way possible as a means of achieving peace and respite grows. It is perhaps a forlorn hope but a continuing one. The victim feels that by making some admission, that by giving his interrogator what is asked for, the desired peace and solace will be achieved.

As Michael Shipkov wrote, ". . . and after a time of this I broke down. I told them I was willing and eager to tell them all they wanted. The main appeal is to end the pain, to stop needless futile resistance, and to come nearer to the moment when they would let me in peace. And there is enormous deception there, even more in the successive breakdown of any remaining resistance."[40]

And later, in Mr. Shipkov's words: ". . . they are not overly interested in what you tell them. It would appear that the ultimate purpose of this treatment is to break you down completely, and to deprive you of any will power or private thought or self-esteem, which they achieve remarkably quickly.

". . . They appear to place importance on the . . . appearance of repentance and self-condemnation that comes up with the breaking down of their prisoner."

At times drugs are used to add to the individual's confusion. These include synthetic drugs of the mescal group. At other times a temporary stimulant is given to prevent sleep or collapse, as benzedrine or amphetamine, analogues such as actedrone, and possibly caffeine and coramine.

In the next phase the individual has already made some admissions in the vain hope of being left alone. Now he is conditioned to accept his confession and to elaborate upon it. His hope of surcease, by having given his interrogators something of what they wanted, has indeed been vain. If anything, this has been indeed encouraging to them, spurring them on to greater efforts as it presages further surrender and the eventual collapse of will which can now be anticipated from prior experience.

A third stage often begins here, in which a predetermined relationship is set up with someone who identifies himself rather closely with the prisoner and acts to encourage in subtle and indirect ways the efforts made and the changes desired. He often plays a rather sympathetic role to the victim and helps to hold out hope and assurance of better treatment as, and if, the victim will more and more fit into the wishes of his captors.

In the final phases the victim has now been completely conditioned to accept his own guilt. He is trained in turn to bear false witness against himself and against others. He is prepared for trial. Now he becomes softened completely, is remorseful, and is willing to be sentenced. Desired trial responses are endlessly rehearsed.

One can imagine how complete this treatment is, from the appearance of the victims in public and on trial. In many instances there has been little indication from casual outward observation that the person is doing other than what he completely and voluntarily wills. It is not surprising that many observers have been completely or partially "taken in" in the past, accepting the "confessions" as bona fide and the court appearances as genuine.

Group efforts cannot achieve the same depth of modification and change. As a result, this treatment has been reserved for people of considerable importance, i.e., where the political advantage to be gained has been regarded as considerable. These factors, plus the requirement for skilled operators, constitute a certain safeguard. Mass application of brain washing is simply not feasible. The moral condemnation and loathing of such inhuman methods by free people everywhere is another safeguard. Actually, the requisite cruelty for the diabolic successes of prisoner-processing tests the credulity of the average person in the western world who may find such ultimate evidence of man's inhumanity to man almost unbelievable. In comparison, the "third degree" of discredited police methods is a game of "ring-around-a-rosy," and the tortures of the Spanish Inquisition were mild.

The operators must balance their efforts in bringing the maximum pressures to bear, at the same time conserving the life and sanity of the hapless victim. Undoubtedly few enough people have the necessary personality attributes of callousness, detachment and obliviousness to human suffering plus an absence of empathy or identification to enable them to develop the requisite skill and technic. However, there are no doubt pressures also operative here to help require success. The life of the operator who fails with an important case could hardly be of little more import to his masters than the integrity of his intended victim which they endeavor to shatter.

In conclusion, the conditioning or processing of prisoners poses a serious threat to humanity. Unquestionably the level of results achieved pose certain scientific questions worthy of further study as to the relative importance of mental and emotional conditioning in man. Soviet psychology has laid the major emphasis on Pavlov's work and has based theory and practice upon extensions and refinements of the concept of the conditioned reflex. Likely their successes with the conditioning of prisoners serve them as a further kind of grisly, human experimental proof. As a threat to man, however, it is more insidious, dangerous, and cruel than physical torture, and there are less barriers or defenses against it. Actually no individual is safe from the threat in the hands of skillful, determined, and unprincipled persons. Even the best psychologically integrated person is subject to complete alteration of his personality and mental structure through the pressures which can be brought to bear.

When it is possible to secure the release of a victim, rehabilitation is feasible, although it is doubtful if the deeply ingrained personality-disruption effects can ever be completely removed. Treatment should aim at the recreation of personal integrity and security and to counteract the effects of the erstwhile heavy-continuing weight of terror. The level of self-esteem must be raised. The victim will have suffered shattering self-doubts, guilt and recriminations, particularly if he has been forced to involve others in his "admissions" and "confessions." His suffering as a victim has been only too much already, without the added burden of self-blame and accusations which are unrealistic in the face of the pressures to which he has been subjected.

TREATMENT

A prime factor in the psychologic treatment of this group of neuroses following trauma is the promptness with which such therapy is instituted after the traumatic event. The prognosis in many cases becomes gloomier in geometrical proportion as time progresses. This is particularly true in those cases in which compensation becomes important. Although I refer here primarily to material compensation, this applies also to psychologic compensation. The latter is represented through the satisfaction of strong, deeply hidden dependency needs and through the achievement of a more passive position. Treatment also has a discouraging outlook in certain industrial compensation cases, cases where litigation impends, or where a disability pension fits in with the neurotic needs for dependency and for a regressive retreat into a more passive, less active role. In speaking of this "external . . . advantage through illness," Freud[42] noted that whenever it "is at all pronounced, and no substitute can be found for it in reality, you need not look forward very hopefully to influencing the neurosis by your therapy." In relation to these factors of secondary gain and compensation, Wechsler[43] also noted the "comparatively bad prognosis."

In many of the cases which have progressed into a seemingly placid kind of sad chronicity one may see the more or less obvious regressive retreat into dependent passivity. A "successful" withdrawal has been made to an earlier, more child-like level of adjustment where one is cared for (by society, pension, compensation, etc.), even though poorly. To the neurotically sick patient, on one level these often minimal or marginal compensations of dependence are worth far more in self-defeating fashion than the much better living which constructive investment of the same amount of energy could bring him. In many of these cases the traumatic event seems to have provided the impetus or to have precipitated the process for which the psychologic preparation had long been in progress.

This discussion would not be complete without an illustration of the involved, unfortunate, and prognostically nearly hopeless kind of situation seen in only too many industrial compensation cases.

Case 10. *An industrial compensation case (modified from Laughlin and Ruffin*[44]*).* A 52-year-old machinist, Mr. M., sought review of his claim for compensation and increased benefits after 3 years of inability to work. He reported symptoms of nervousness, loss of ability to concentrate, and weight loss. A steady increase in symptoms was also reported, so that he was now unable to undertake any activity involving physical exercise. He described an increasing diminution of right visual acuity to the point where he could barely see. All his difficulties were attributed to an auto accident several years earlier. Although he would describe in great detail his many disabling symptoms and the terrific handicap in living they represented, this was presented in a bland way as though he were talking about someone else far distant (cf. *la belle indifférence* of conversion hysteria[45]). Any inquiry into family relationships or emotional adjustment was answered curtly, if at all, conveying an attitude as if to say, "Why in the world do you ask such silly things! That's got nothing to do with my symptoms. I'm disabled and can't work. After all, I'd be glad to go back to work if only you would fix me up (of course, if you can't do that then I guess I'll have to have the compensation)." This, of course, is entirely accurate from one viewpoint. If the doctor could do away with the underlying neurotic needs, the patient would indeed be glad to return to work. Sadly, he is disinterested and unable to assume the necessary responsibility in this direction himself. Without the patient's active coöperation, the physician is helpless. He alone cannot do it for the patient.

The history disclosed a very minor accident in a company truck nearly 4 years earlier. At the time it was not serious enough to report to the police, his supervisor, or even for any slight damage to the truck to be noticed by company employees. Six months later, however, he developed a right eye infection which he soon attributed to this accident. He became increasingly nervous and unable to concentrate. Several competent examiners had ruled out organic reasons for the visual impairment, although it continued to interfere progressively with the patient following subsidence of the initial conjunctivitis. Nervous manifestations became so severe as to force the patient to leave employment abruptly. Unbeknown to him, his work efficiency and performance had become so unsatisfactory that he barely succeeded in leaving ahead of involuntary separation proceedings, which were actually in process at the time. Needless to say, efforts to interest this man in any kind of constructive introspection were fruitless. Although he had no conscious awareness of the fact, the illness had become too fixed and his compensation (actually his passive-dependent position) too important to him. His neurotic needs were satisfied too well by the yet self-defeating, psychologically uneconomic, and tragic "gains" of his illness.

Relatively few patients of this kind ever sincerely seek or accept psychiatric treatment. A cure would result in a loss of their dependent condition. Often they have a great need to prove to themselves and to others a physical basis for their symptoms and disability. They often regard any implications of psychologic factors in their illness as some kind of accusation or affront. Thus, they are most often unable to accept a beginning step in the consideration of possible emotional factors. They may verbally express a desire for "cure," but it is as though their self-respect required them to have an organic origin for their symptoms. This becomes, however, more importantly an ironclad defense against the possibility of therapeutic intervention into the "balanced" neurotic position achieved. In most instances this bars the way for any exploration of emotional data which may be actually playing the major role. The patient does not want to accept responsibility or to invest the required time or effort for insight-directed therapy. Actually, on a more hidden level he desperately guards the neurotic *status quo* as though this position of sacrifice and defeat (from any objective judgment) was most precious and vital. Emotionally it is.

Unless psychotherapy can offer something better these particular patients are only too often refractory to psychiatric investigation and treatment. Their emphasis is unfortunately upon proving the reality of their disability rather than upon finding out about possible personal internal factors which may enter into their need to continue a disabled existence with compensation. They are really satisfied with an adjustment on a relatively nonresponsible or infantile level of dependence. Theirs is often a sad dilemma and a hopeless, unhappy position.

In contrast, in many acute cases, and particularly in those in which the prior adjustment was reasonably sound, therapy can be highly beneficial. This is true in many cases of gross stress reactions of civilian or combat origin. Herein limited and temporary gratification of what may be regarded as emergency dependent needs may be helpful. Rest, reassurance, food, sleep, shelter, and judicious use of sedation can be very effective adjuncts in providing a temporarily more favorable climate to allow reintegration of defenses, remobilization of depleted psychologic resources, and the regaining of a sense of personal mastery over a recently overthreatening environment. Ross[46] also included some excellent guides for the handling of the emotional illnesses incident to war. Another valuable adjunct is therapeutically encouraged catharsis and abreaction in skilled hands. The repetitive dreams are one of nature's attempted steps in this process. Interviews judiciously conducted can be very helpful.

Grinker[47] has described the use of what he has named "narcosynthesis" in the North African theater in World War II. With the use of sodium pentothal he learned that treatment in many acute cases could remove severe symptoms rapidly. With this type of traumatic war experience occasional instances are seen in which successful therapy can be conducted after a lapse of some years. The following case is an illustration.

Case 11. *Successful narcosynthesis of a chronic post-combat neurotic reaction.* A 28-year-old sergeant was admitted to a service hospital in 1949 because of nervousness, fatigue, crying spells, irritability, and loss of effectiveness at duty. The history disclosed almost constant difficulty following reënlistment in the service about a year previously. His early background was relatively stable. He had possibly slightly more than the usual adjustment difficulties with several brothers and a tendency to worry and had always been rather conscientious. He had enlisted in the Army early in World War II, had done well, and had participated in the North African campaign as well as in the invasion of Sicily and Italy. He had no difficulty until following a tank engagement in early 1943, with increasing emotional symptoms since that time. He left the service and after a period of restlessness and dissatisfaction had reënlisted.

On examination he was tense, anxious and restless. He was tremulous at times, had trouble sleeping, and still suffered from startle reaction and occasional battle dreams even after 6 years. He appeared depressed and reported crying spells. Despite the length of elapsed time since combat, he still presented many of the earmarks of the acute case, in view of which treatment offered good chances. Interviews were begun with sodium amytal. An amazing quantity of dramatic emotional material was produced. Several times he "relived" the desperate battle scene in which his tank was hit and set afire and he alone escaped. While he lay pinned down by intense gunfire near the tank, it burned. He heard the terrified screams for help of his trapped crewmen whom he was powerless to help. Although he had previously "successfully" repressed much of this painful scene and his conflicts and soul-tearing irrational feelings of guilt and responsibility from conscious awareness, it became possible now to deal with this terribly disturbing material on a conscious level. Factors were brought out tying back to his early family situation and especially his relations with his siblings, represented by his tank crew.

Rather rapidly he was able to resynthesize his adjustment and to accept the terrible events on a more objective level. He came to terms with himself and at this delayed date was able to reassert his mastery over the long-past external threats. His depression lifted, he became cheerful, lost his irritability and other acute symptoms, and returned to duty.

In general, however, the more promptly this approach is utilized, the better the results. It is also to be noted that despite occasional instances of success, notwithstanding years of symptoms, narcosynthesis offers relatively little in the more usual civilian neurosis. Further, its use is to be generally avoided except in expert hands and in judiciously selected cases. Patients will often seek such treatment as a hoped-for, painless and easy kind of cure which would enable them to take a more passive position in the therapy. Generally the therapist had best give such requests little consideration and rule out the possibility politely, but promptly and firmly.

From the standpoint of theoretical considerations every traumatic event has its prior analogue in early life. This is also in accord with the theory of antecedent conflicts,[43] by which every disturbing event of later years may have its effect multiplied, sometimes vastly so, through earlier vicissitudes of life which are analogous and antecedent (actually or symbolically). In effect, the later event appears to reactivate the long-dormant and hidden conflicts and disturbances of the earlier ones. It is as though the original trouble creates an emotional sensitization for the later in which the psyche then reacts out of proportion at the time of the subsequent event. At times the resolution of the earliest accessible "antecedent conflict" is essential for permanent, thorough-going solution of current difficulties. Obviously this can indeed be a difficult process. At other times more limited therapeutic goals are more feasible and practical.

In closing these brief remarks on therapy there is a distantly related phenomenon about which I would like to comment. I refer here to the seemingly paradoxical increase of anxiety and sometimes also of symptoms following the initiation of therapy. The emotionally sick patient is troubled but is unaware of the real sources of his difficulty. Psychoanalytic therapy aims at the uncovering, clarification, and resolution of conflicts. Often these have been protectively repressed from conscious awareness. In successful treatment, awareness is increased, gained or regained. Only thereby can conflicts be discussed, with resulting possible desensitization, resolution, and the banishment of irrational and nonrealistic elements. This inevitably arouses a recurrence of some of the original distress which resulted in their having been earlier banished to the unconscious. Thus, the seeming anomaly is seen not infrequently of the patient who feels worse under early treatment, where this is actually a sign of progress (cf. discussion following case 7[19]). The neurotic patient is troubled but is often unaware of the real reasons, the extent, or the degree until increased awareness is gained through treatment.

Acknowledgment: The preparation of this series has proved to be a project of much greater magnitude than was originally envisaged. Accordingly, I am very grateful for the kind reception which these articles have received. The encouragement and support from many of my medical colleagues have served as a needed additional stimulus. I would also like to acknowledge the many useful suggestions and comments from several score of my esteemed colleagues in Washington and

(Continued on page 604)

President's Page

KNOWLEDGE, FELLOWSHIP AND ENTERTAINMENT

On November 1, 2 and 3 our colleagues from the "sacred side of the Potomac" will arrive in this "mecca of medicine" to join us in the First Interstate Scientific Assembly. They will bring "gifts" too, to add to the "meat" and "spice" of a program which is most impressive.

Joint committees from the two Societies have worked faithfully to give you an outstanding meeting. You will find that very little has been omitted; there is a message in the scientific papers and in the exhibits for each and every one. And remember, the commercial exhibitors have a message for you also.

There are knowledge, fellowship and entertainment to be found in the halls of the Shoreham on November 1, 2 and 3.

Preston A. McLendon

FEE-SPLITTING AND THE CLOSED HOSPITAL

Each day there can be read, either in the lay press or in medical journals and bulletins, articles concerning fee-splitting in the medical profession. The American College of Surgeons, particularly, has been waging a campaign against this evil. It is a wonder that no one has tried to determine why it is that certain sections of the country are practically free from this reprehensible practice, while in other sections, notably large cities, the practice is almost universal. It is a well-known fact that here in the District of Columbia few if any doctors have succumbed to the temptation to split fees. It might be well to try to analyze the reason why.

It is the belief of many medical men who have come here from other communities that one of the main reasons why medical ethics is on such a high plane in the District of Columbia is because all of our hospitals here are what is commonly known as "open hospitals." This means that any physician may send his patients to any one of our hospitals, provided he has been granted courtesy privileges at the hospital. This allows him to treat his patients without any interference from members of the active staff of the hospital, and he is in no way obligated or required to utilize the services of members of the active staff when he calls a consultant. In other words, he is a perfectly free agent as far as his patients are concerned. This condition, he knows, will continue to exist as long as he does not attempt to carry out some procedure he is not qualified to perform, or administer some treatment he is not skilled enough to use. The executive staff of each of our hospitals, throughout the years, has had a credentials committee which carefully reviews the credentials of all candidates who make application to the hospital for privileges, and if these applicants are qualified for the privileges they request, they are invariably granted access to the hospital.

It is the constant complaint of young men from localities where closed hospitals exist that they are required to turn their patients over to some member of the active staff of the closed hospital. Frequently, the young men have been trained in large centers and often are better qualified to take care of their patients than the hospital staff member.

Years ago there may have been some moral justification for a hospital to require physicians to turn over cases to staff members, because so few physicians were adequately trained. An 'M.D.' degree was all that was required to practice medicine, and many men never bothered to take an internship. The closed hospital staff arose from the necessity of the hospitals to regulate the standard and character of practice that went on within their doors, and the hospitals had a moral obligation to see to it that their patients received the best care that the community could offer. These requirements no longer exist with the present high standards of medical training.

The "closed hospital" policy is morally and ethically wrong, and breeds another evil, "fee-splitting." It places an economic barrier against young men starting practice, when their economic burden is so great, and they might easily

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia

be tempted to deviate from the strict rules of ethics. When subjected to such injustice, they will often rationalize when temptation to split a fee comes their way. Frequently, small sanitariums and hospitals of questionable reputation will spring up and welcome with open arms qualified young men, provided they are willing to split their fees. This bartering in human suffering is as much the responsibility of the "closed hospital" staff members, even though they do not split fees themselves, as it is the young men who succumb to the temptation. There is absolutely no ethical reason why hospitals should close their doors to any qualified physician.

Fee-splitting is not limited to localities that have closed hospital staffs, however. Even in "open hospital" communities, fee-splitting will go on if the beds of the hospitals are limited to only a select few. In some instances university hospitals must limit their beds for teaching purposes to members of their teaching staff. Even in these hospitals it is not necessary to shut the doors completely to well-qualified physicians. Particular attention should be given to university medical school graduates who frequently have their internship and residency at the university hospital and, when they finish their training, are unable to obtain privileges or bring patients into their own hospital.

There is nothing wrong with a hospital showing preferential treatment as far as beds are concerned. Doctors who regularly support a given hospital should be given first choice as to bed space. Over and above this, the beds in a hospital should be available to the patients of any qualified physicians on a "first come, first served" basis.

Those sections of the country troubled with this vicious practice of fee-splitting could well look toward the District of Columbia and study the doctor-hospital-patient relationship as it exists here. It is a tribute to the older members of the medical profession who have maintained our "open hospital" policy. They have set a good precedent for the younger men who will follow in their footsteps and who will someday have positions of authority in our hospitals.

Philip A. Caulfield, M.D.

THYROID DIAGNOSIS

The most frequent cause of erroneous diagnosis of thyroid disease is the single determination of the basal metabolic rate. What the early investigators of the BMR fully realized, and what now does not seem so well appreciated, is that this test must be carried out with great care, by experienced operators, and usually in serial determinations. Any attempt to ascribe arbitrary limits of -10 to $+10$ as "normal" rates is unwise, since normal patients may have rates as low as -20 to -30, and it is well known that nervousness or a perforate eardrum may result in $+30$ or more.

The plasma cholesterol value is also used widely in the diagnosis of thyroid disease. If the level of cholesterol is low it helps to confirm the diagnosis of thyrotoxicosis. Conversely, the myxedematous patient usually is hypercholesterolemic. Nevertheless, this relationship between thyroid function and the serum cholesterol level is so inconstant that, at best, the cholesterol determination is only of confirmatory value in the diagnosis of altered thyroid function.

The newer tests of thyroid function, I^{131} uptakes and the determination of the serum iodine level of the blood, provide practical, accurate methods of thyroid diagnosis.

The 24-hour thyroidal uptake of a tracer dose of I^{131} is between 10 and 45 per cent of the dose in normal patients. Below 10 per cent uptake is found in hypothyroidism and acute thyroiditis, whereas uptakes over 45 to 50 per cent are found in untreated hyperthyroidism.

The serum protein-bound iodine determination is a measure of circulating thyroid hormone. In the Georgetown University Hospital laboratory the range of normal values is 3 to 7 micrograms per cent. A decrease or increase in the activity of the thyroid gland is reflected in a corresponding change in the level of the serum protein-bound iodine. It is a valuable test of thyroid function, particularly in those cases of goiter with normal or elevated uptake of I^{131} in which I^{131} concentration does not accurately reflect hormone production.

A final addition to the thyroid armamentarium is the response of the patient with myxedema to a test dose of thyrotropin (TSH). If the myxedema is secondary to hypopituitarism there should be a significant increase in I^{131} uptake and the protein-bound iodine level of the blood, whereas the spontaneous myxedema patient does not respond to exogenous pituitary stimulation.

The big problem in the use of either the I^{131} or protein-bound iodine test is that administration of iodine containing medication or X-ray compounds, particularly gallbladder dye, will disrupt both tests for prolonged periods of time. In any diagnostic study, therefore, the thyroid tests should precede the cholestogram or intravenous pyelogram if these tests are to reflect their true accuracy as sensitive indices of thyroid function.

B. J. Duffy, Jr., M.D.

OLD MEDICAL BOOKS

It may be as difficult to define an old medical book as to define an old woman, but be that as it may, for general purposes a medical book is old if it has been published 10 years or more. This applies to almost all fields of medicine with the exception of anatomy, for contrary to advances in the arts and sciences, the anatomical man has remained unchanged, grossly at least. His tenure of life has been extended many years despite the assaults of modern living, cigarettes and automobiles, but fundamentally he is the replica of Adam.

Our present concepts of physiology, biochemistry, and therapy have had a profound influence on medical and surgical treatment, even in the memory of most of us. When we look upon the volumes on our shelves, we must realize that many of our books which we purchased with eagerness in our early days, particularly those encyclopedias, and three- or four-volume treatises, belong in the category of old, and almost forgotten, friends. The early editions of Osler, for instance, bring back visions of the master clinician. His meticulous paragraphs on symptomatology are as crystal clear today as when they were written. The research in pharmacy, biological chemistry, and surgery have relegated some of our finest contributions to the limbo of old books. In the field of surgery, or any specialty thereof, books 20 years old make slight reference or none at all to operations upon the lung, the heart, or the vascular system. Neurosurgery and plastic surgery have emerged almost as new fields. Fractures are no longer treated exclusively with splints, casts, pulleys, and ropes, but have been supplemented by ingenious mechanical fixation and grafts.

Medicine has not lingered by the wayside. Prescription writing is a lost art, if it ever were one. What is the answer? There is only one. Go over the entire collection of books and eliminate those of ancient vintage (10 years plus). Do not think for a moment that they have a monetary value or that any library, medical society, or hospital would be glad to accept them. There is a receptive depot, and your hospital librarian can arrange to dispose of them. Their final resting place will probably be in some far-off land, where books even 10 years old will find enthusiastic readers.

C. S. W.

GIVING—PLUS

The Community Chest campaign this year has for its slogan four words—"Last Year's Giving—Plus," but in my appeal to you I am going to emphasize the last two words as particularly significant. It's the PLUS in any gift that gives it value; it's the PLUS in giving that makes it different from a hand-out; it's only the PLUS that will ever put the Community Chest or any other campaign over the top. The PLUS is yourself and myself; it's the spirit of giving which we ourselves bring to this campaign; it's the enthusiasm for giving which we instil into our colleagues, our patients, our neighbor down the street. We are the community, and in this one big, unselfish act we reflect like a mirror what we think of ourselves in relation to our community.

If all of us could spend even an hour in each of the voluntary agencies which these funds support, there would be no question of making the quota. I do not believe that those of us who do see many of these institutions need much urging to give; we do need reminding.

So let me remind you that again October is Red Feather Month. Let me suggest that the Community Chest is a real community investment and that your share in it is a privilege as well as a responsibility. Let me ask you to secure your share in this investment with the same thoughtful planning that you would bring to the purchase of any other worthwhile security. The price? In proportion to your estimation of your value to your community. Sound securities are never cheap. The dividends? One hundred and one volunteer agencies enabled to function for another year, meeting the needs of those who cannot help themselves. Only one share per capita required annually in community giving; let's make the price par PLUS.

Paul Kiernan, M.D.
Chairman, Physicians Group,
1955 Red Feather Campaign,
National Capital Area

In and Out of Focus

BY THE OBSERVER

Narcotic Regulations Reports of violations of the narcotic laws appearing in the Washington newspapers during the past months were responsible for a number of inquiries being received at the Medical Society's offices. While most physicians were familiar with essential requirements of the Federal and District narcotic laws, they were uncertain as to what records they must keep of narcotics administered, dispensed or used professionally.

For the benefit of those who may not be clear on this point, the following quotes from the District law should be a sufficient guide:

> "Sec. 11. (a) Every physician . . . who is authorized to administer or professionally use narcotic drugs shall keep a record of such drugs received by him, and a record of all such drugs administered, dispensed, or professionally used by him otherwise than by prescription in accordance with the provisions of subsection (e) of this section. [See below.] It shall, however, be deemed a sufficient compliance with this subsection if any such person using small quantities of solutions or other preparations of such drugs for local application shall keep a record of the quantity, character, and potency of such solutions or other preparations purchased or made up by him, and of the dates when purchased or made up, without keeping a record of the amount of such solution or other preparation applied by him to individual patients."

Subsection (e) reads in part:

> ". . . The record of all narcotic drugs sold, administered, dispensed, or otherwise disposed of, shall show the date of selling, administering, or dispensing, the name and address of the person to whom, or for whose use . . . the drugs were sold, administered, or dispensed, and the kind and quantity of drugs. Every such record shall be kept for a period of two years from the date of the transaction recorded. The keeping of a record required by or under the Federal narcotic laws, containing substantially the same information as is specified above, shall constitute compliance with this section, except that every such record shall contain a detailed list of narcotic drugs lost, destroyed, or stolen, if any, the kind and quantity of such drugs, and the date of the discovery of such loss, destruction, or theft."

There are, of course, other provisions with which physicians should be familiar. A number of these were recently underscored for the information of the Medical Society in copies of the Federal and District laws forwarded to the Secretary by the office of the Bureau of Narcotics, Treasury Department, Baltimore, Maryland. Physicians can obtain copies of the Opium and Narcotic Laws and the Federal Narcotic Law and its Regulation No. 5 from the U. S. Government Printing Office at a nominal cost.

Enclosed with the above material was a list of the following "Don'ts" for physicians in the prescribing and use of narcotics:

Don't leave prescription pads around. Addicts want them for effecting narcotic forgeries.

Don't write a narcotic prescription in lead pencil. Avoid writing any Rx in pencil; many are changed to call for morphine.

Don't write for narcotics this way: Morphine HT ½ # X *or* Morphine HT ¼ #10. Several X's or zeros can be added to raise the amount. Use brackets, or spell out.

Don't carry a large stock of narcotics in your bag. Addicts are constantly on the lookout for these in doctors' offices and cars.

Don't leave your car unlocked if your bag contains narcotics. This is an invitation for the addict to steal narcotics.

Don't store your office supply where patients can get at it. Avoid storage near sink or urinal. The patient may ask to use these.

Don't fall for a good story from a stranger claiming ailment that usually requires morphine. The addict can produce bloody sputum, simulate bad coughs or other symptoms. Make your own diagnosis.

Don't give a narcotic prescription without seeing the patient. Addicts have posed as nurses to get doctors to prescribe narcotics.

Don't write for large quantities of narcotics unless unavoidable. Diversion to addicts is a profitable business: as much as $3.00 for ¼ gr. Morphine Sulphate.

Don't prescribe narcotics on the story that another doctor had been doing it. Consult that physician, or the hospital records, whenever possible.

Don't leave prescriptions signed in blank at the office for nurses to fill in. Signed blanks are bad practice and many have been stolen by addicts.

Don't treat an ambulatory case of addiction. Addicts must be under proper control. Addicts go to several doctors at a time. Notify this Bureau—Executive 3-6400, Extension 788.

Don't dispense any narcotics without keeping a record of it. Bedside and office administration are permitted without a record.

Don't buy your office narcotic needs in the name of a patient. The law requires you to use an official opium order form.

Don't resent a pharmacist's call for information about a prescription you have written. The pharmacist is held responsible for filling forgeries. Please coöperate.

Don't hesitate to call this Bureau to get, or give, information. It will be held strictly confidential.

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"They Don't Print Our Side!"

About a month ago, on a flight from Chicago to Washington, your Observer fell into conversation with a representative of a labor union. He related in some detail the difficulties his union had had with employers. Irked with them, he was particularly bitter toward the newspapers, whom he angrily accused of favoritism, saying, "They don't print our side!"

This had a familiar ring. How often doctors have been heard to say the same thing. The inference is that the press is unfriendly and seeks by means of unfavorable news reports to undermine public confidence in the medical profession. At the very least, they say, newspapers are prone to play up criticism and controversy to the exclusion of contributions made by the profession to the public welfare.

There is no denying that unfavorable news stories have appeared—too many of them. On the credit side, however, there have been many more that inspire confidence. This observation is based on a daily check of Washington newspapers, which devote as much or more space to medical matters as do newspapers in other metropolitan centers.

It is true that most of the so-called favorable stories are concerned with scientific aspects of medicine, those of a critical nature being largely in the political and socioeconomic field—Government versus private system of medical care, medical legislation, and various methods of paying for medical services. This should occasion no surprise, for this has been and will continue to be a controversial area for some time to come.

As is well known, controversy is news and newspapers make the most of it. It is their business to print views on both sides and to present facts in an objective manner. To do this to the satisfaction of all concerned is, of course, impossible. On the other hand, even newspapers known for their integrity in the matter of news at times place undue emphasis on certain facets of a story which lead one to suspect where their sympathies lie. Infrequently a report is factually incorrect. On the whole there would seem to be little justifiable complaint on this score where Washington newspapers are concerned. They may not see eye to eye with the medical profession in their editorial columns but they do aim to be factual in their news columns.

If we are honest with ourselves, the situation boils down to this: We, like the union representative, are troubled when we appear in an unfavorable light, especially in the press. We have a feeling that if a newspaper was friendly it would omit what we feel is unjustified criticism and publish what we know to be the whole and true story. We are reluctant to admit, even when we know it is true, that our medical organizations make mistakes. We cannot reconcile ourselves to being involved in controversy where sometimes intemperate and unfair statements are made about us.

This is not to suggest that our position on most issues under debate is not sound, or that we should not seek a better press, but to urge that we take a more philosophic view of our relations with newspapers. Regardless of criticism in the press, if our stand on such vital matters as the health of the people is primarily in their interest, it will prevail.

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Highway Carnage

From the avalanche of printed material which floods the Society's daily mail, your Observer recently extracted an attractive booklet issued by the Travelers Insurance Company entitled "The Passing Scene." The Company's President, J. D. DeWitt, in a brief foreword, states that its purpose is "to bring the traffic problem into sharp clear focus."

This is done most effectively by means of simplified statistical tables, supplemented by grimly humorous drawings by the country's leading cartoonists who "exaggerate our stupidities and prick the bubble of our pretences." The net result is that even the most cursory reader is deeply impressed by the needless carnage on our highways.

Some of the sobering and illuminating facts contained in the booklet are:

Traffic Deaths: In 1953 38,500 persons died in automobile accidents of various sorts, as against 37,600 in 1952. Last year there was a death every 14 minutes in such accidents.

Traffic Injuries: In 1953 an astounding total of 2,140,000 persons were more or less seriously injured in automobile accidents as compared with 2,090,000 in 1952. Autoists suffered injuries every 15 seconds in 1953.

Causes of Accidents: Figures here are especially illuminating. They show that approximately 46 per cent of the accidents resulting in death, and 40 per cent causing injury in 1952–1953 occurred when drivers were exceeding the speed limit; 25 per cent when the drivers did not have the right of way; and 10 per cent as a result of reckless driving.

Age of Drivers: 24.5 per cent of the drivers in fatal accidents in 1953 were under 25 years of age; 70.3 per cent were aged 25–64; and 5.2 per cent 65 years and over. There was only slight variation in these figures for the year 1952. As for drivers involved in non-fatal accidents last year, the percentages were 19.4 per cent for drivers under 25; 77.7 per cent for those in the 25–64 age group; and 2.9 per cent for those 65 and over. The percentages in 1952 were approximately the same.

Operating Experience: The percentages for 1952–1953 show from 2 to 4 per cent of these drivers had less than one year operating experience, 96 to 98 per cent had driven one year or more, indicating, according to the pamphlet, that "familiarity breeds contempt."

As for the sex of the drivers involved in accidents, fatal and otherwise, during 1952–1953, about 90 per cent were male.

Types of Motor Vehicles: 76.6 per cent of the vehicles involved in fatal accidents in 1953 were passenger cars. Passenger cars also comprised 83.5 per cent of the vehicles involved in non-fatal accidents. Approximately the same percentages apply to 1952.

Condition of Motor Vehicles: In both years, 96 to 98 per cent of the vehicles involved in fatal and non-fatal accidents were "in apparently good condition."

Weather: Here, too, where both fatal and non-fatal accidents were concerned, the weather was clear in about 80 per cent of the cases. Road conditions were also good, that is, dry, in about 75 per cent of the accidents. The day on which accidents rose to their highest peak was Saturday and the dangerous hours were between 4:00 and 8:00 p.m.

Direction of Travel: Here is the paradox. The majority of accidents did not occur when turning, backing, parking, and so on, but when a car was "going straight."

From these facts it is only too obvious that if motorists could be induced to take a few precautions and to use a little common sense, thousands of traffic deaths and injuries could be avoided. Highway officials and others directly concerned with this matter have felt that an adequate training program, especially for the younger age groups, would bring about an improvement. Where it has been tried it has helped materially, and therefore should be encouraged.

Human nature being what it is, however, education of itself is not sufficient. Where possible, further steps must be taken to protect motorists against themselves. Being of this opinion, the Arizona State Medical Association and the Colorado State Medical Society introduced somewhat similar resolutions at the San Francisco meeting of the AMA's House of Delegates, calling upon the motor car manufacturers to take measures which would aid in reducing the frightful traffic toll by equipping all automobiles with safety belts which would withstand impacts up to 15 G.* The Arizona resolution also urged that equipment include roll-over bars, non-energy-storing padded dashboards, recessed knobs, and securely locking doors. The Colorado Society would include seats, cushions and doors to withstand impacts up to 10 to 15 G. without injuries.

Both of these resolutions were referred to the Reference Committee on Hygiene, Public Health, and Industrial Health, which approved them in principle but offered the following substitute resolution, which was adopted:

"RESOLVED, That the American Medical Association recommends to motor car manufacturers of America that they consider equipping all automobiles with safety belts and, furthermore, that they give increasing emphasis to safety design of all automobiles."

Automobile manufacturers have, of course, been well aware of this problem and as new models come out they have included additional safety devices. Undoubtedly, they have also considered some of the suggestions offered in the Colorado and Arizona resolutions. Whether or not these are practical, the interest of physicians in reducing the highway toll should prove a stimulus to further efforts to make the automobile mechanically as safe as possible.

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Hazards in Sports

Considering that millions of our people participate in competitive sports, it is not surprising that fatalities occur and that many contestants are more or less seriously injured.

As there is no way of knowing the exact number who take part in athletics, an over-all estimate of fatalities and injuries is not available. However, the *Statistical Bulletin of the Metropolitan Life Insurance Company* for June, 1954, points up some interesting facts. For example, the *Bulletin* states that among several million males between the ages of 10 and 29 years insured by the Metropolitan Life Insurance Company, there were only 11 deaths resulting from competitive sports in the years 1951–1952. In the Company's experience, this is less than one in every 300 accidental fatalities of all types.

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* In aviation, a belt which will withstand an impact of 15 times an average person's weight or 170 lbs.

The infrequency of fatal injuries in sports is also shown by the experience in New York City, where in three decades there were approximately 100 deaths, an average of only three a year. Baseball, football, and boxing, in this order were responsible for four fifths of the deaths.

Nationally, the figures available are not so comforting. In the period 1949–1953 football accounted for 94 deaths. Listed as causes of 65 of these fatalities were tackling, blocking, and piling up. The remaining 29 were attributed to infection, heart failure, pneumonia, and other causes resulting from the game.

A further breakdown of football deaths, showing their source, follows:

	Direct cause of death	*Indirect cause of death*
College	4	4
High School	37	12
Professional and semiprofessional	9	3
Sandlot	15	10
Total	65	29

Source of data: Dr. Floyd R. Eastwood, Chairman, Committee on Injuries and Fatalities, American Football Coaches Association.

Boxing during the same period claimed 29 participants; 17 of these were amateur fighters and 12 were professionals. The *Bulletin* points out that the deaths among professional boxers have decreased in recent years, due largely to efforts of the state boxing authorities to make the sport safer.

On the basis of the Metropolitan's experience, it is probable that baseball accounted for more fatal injuries than any other sport. This conclusion is arrived at because of the wide popularity of the game and the large numbers participating. Interestingly, there have been no fatalities among the approximately 400 players in the major leagues since 1920.

As millions of participants know, golf also has its hazards. The *Bulletin* reports three deaths among Metropolitan policyholders in 1951–1952, one player being fatally injured when hit by a ball in flight, another was struck by a club swung by another player, and the third was struck by lightning while on the course.

It will undoubtedly come as a surprise to many readers that in professional hockey, certainly one of the most rugged of professional sports, there has not been a death since 1937. Neither is there record of a death in professional basketball, while in soccer there has been only one death in four decades. There are no deaths attributed to skating, or roller derby contests, in which some 100 skaters compete each year, since their inception in 1935.

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Still a Cult?

Under the caption "Osteopathy—A Cult?" Dr. Louis J. Bailey, Editor of the *Detroit Medical News*, official publication of the Wayne County Medical Society, takes a dim view of the opinion expressed by the Committee for the Study of Relations between Osteopathy and Medicine in its report to the AMA's House of Delegates last June. The report states "the justification or lack of justification of the cultist appellation of modern osteopathic education could be settled with finality by direct on-campus observation and study of osteopathic schools. . . ."

"No investigation at this or any other time," Dr. Bailey insists, "would erase the historical facts of the basic tenets of osteopathy and of their repudiation by time and by the practitioners of osteopathy alike. If osteopaths have gone beyond the platform of their founder, they are no longer practicing osteopathy. They are thus practicing a kind of orphaned medicine—the result of either voluntary or involuntary patricide."

Dr. Bailey predicts that little will be accomplished by the Committee except to stir up controversy. If its findings are favorable, he says, they will be widely publicized "with great delight"; however, if they are unfavorable, "the hue and cry of unfairness, of persecution will be raised."

Osteopathy, Dr. Bailey declares, originated in "the fertile brain of an untrained observer, [a] self-taught and peripatetic medical practitioner of the western plains—and in the turn of fortune on a Civil War battlefield which permitted a Minie ball to flick at the tunic of A.T. Still both fore and aft without injury to the wearer."

"Doctor" Still believed that all remedies necessary to treat the patient were compounded within the human body. He was opposed to drugs, vaccination, and serums. Disease was the result of anatomical abnormalities, therefore surgery was not to be thought of except as a last resort.

Now, Dr. Bailey says that "Osteopathy was a complete and advanced school from the beginning; D.O.'s have access to all scientific knowledge (including sulfonamides, serums and vaccines!); it is not a drugless system."

Chiropractic is described as an "off-shoot" of osteopathy, and a "steal" from "Doctor" Still by Palmer, "a family friend and visitor."

It is clear that Dr. Bailey thinks the AMA places itself in an untenable position if it compromises its standards with those of osteopathy. Those who take the same view will certainly make themselves heard when the subject comes up for discussion in the AMA's House of Delegates, either at the December session in Miami, or next June at Atlantic City. On the other hand, those who advocate accepting osteopaths into the family of organized medicine will be equally vocal in their demands if the report on osteopathic schools is favorable.

T. W.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, September 27, 1954, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society.

Active Members

Robert C. Hill, 6631 East Avenue, Chevy Chase, Md.
Ross M. Lehman, Jr., 748 Oglethorpe Street, N.E.
James C. Mandes, 1355 Locust Road, N.W.
Mary Jane O'Leary Matthews, 6420 Wiscassett Road
Jay C. Maxwell, 1323 Tewkesbury Place, N.W.
Joseph Ney, 1801 K Street, N.W.
John J. Nolan, 1835 Eye Street, N.W.
Sam C. Pascoe, 1122 John Marshall Drive, Falls Church, Va.
Raymond Stoller, 900 17th Street, N.W.

Associate Members

Tatiana T. Antonovych, 703 South Walter Reed Drive, Arlington, Va.
Harold T. Dodge, National Institutes of Health, Bethesda, Md.
G. Bowditch Hunter, 24 West Montgomery Avenue, Rockville, Md.
John Martin, Walter Reed Army Medical Center
Gertrude Ungar, 2733 Ordway Street, N.W.

Recent changes in membership status:

Active to Associate

James B. Bain
William H. Hanna
Frank P. Lloyd
Joseph M. O'Neil
Ira W. Pearlman
John C. Ransmeier

Associate to Affiliate

Clifford E. Bagley

Resigned
Active

Thomas J. O'Connor
Marion B. Richmond
John F. Stapleton

DIABETIC "DRAGNET"

WILLIAM KURSTIN, M.D.

Chairman, Diabetes Detection Drive for the Washington Metropolitan Area

One of the great triumphs of medical science within the past generation has been the discovery of methods of controlling diabetes. Today over a million people in this country are under medical care for this debilitating ailment and are helped by their physicians to manage their own illness so that most of them can lead normal and useful lives.

Because of its frequency, the disability it causes directly or indirectly, and because of the high level of its mortality rate, diabetes has become a major health problem. Yet there is scarcely any chronic disease of equal importance for which there can be such a hopeful outlook from the standpoint of both the individual and community. General application of present-day knowledge can save lives, give protection against disability, and even reduce the incidence of the disorder.

It has not always been so. Diabetes has been known and recorded as a common disease for almost a thousand years, but it remained a mysterious and nearly always fatal illness up to our own times. It is impossible to estimate the toll it took of human lives before modern methods of control were discovered. Even today, when diabetics are enabled to live practically normal lives, it still ranks eighth among the leading causes of death by disease in the United States.

The basic causes of the condition are still unknown, although a vast amount of research is being done to uncover them. However, the important fact today is that the medical profession now knows how to treat and relieve diabetes.

The symptoms, when present, are characteristic. Even before symptoms appear the diagnosis can be revealed by the simplest of laboratory tests—the test for sugar in the urine. Yet there is evidence that nearly half the people who have diabetes are not aware of it. Countless individuals never have the diagnosis made until they have suffered impairment of health. Even when the diagnosis has been established, treatment is far too often neglected or inadequate because it does not seem urgent to the patient, because it seems difficult or complicated to the patient or physician, or both. Unfortunately, many diabetics are not being treated today because they do not even know they have the ailment. The symptoms of diabetes may not yet be acute enough to make these individuals go to a doctor, though without treatment the condition may suddenly become very severe.

There is need for public education so that the person who has begun to have symptoms of diabetes will recognize the need for medical attention. Anyone who has frequent urination, thirst, and loss of weight in spite of good appetite should realize that he should see his doctor and have a test for diabetes. Furthermore, it is now known to be greatly to the advantage of the diabetic to discover the condition before there are symptoms which impel him to seek medical treatment. The control of diabetes is easier and treatment simpler; insulin injections are not likely to be needed; complications may be avoided.

It is estimated that there are nearly as many undiscovered diabetics in the country as there are known cases. Pilot surveys indicate, too, that perhaps as many as three million more may be potential diabetics. The search for these unknown diabetics is one of the major tasks of modern medicine. It is essentially the physicians' function and duty to discover the hidden diabetic, just as it is his task to supervise the treatment of those whose ailment has been diagnosed. Consequently, it is of prime importance that any large scale diabetes detection program be placed firmly in the hands of the medical profession.

It is sound policy to promote the plan of having a urine test for everyone every year. This is particularly essential for the relatives of diabetics, the obese, and the elderly. There should also be a routine test of the urine at the time of any illness. Finally, blood sugar tests should be recommended when a positive urine test is noted.

The American Diabetes Association, a national organization, composed mainly of physicians, has set itself the task of conducting this search for the undiagnosed diabetics. The American Diabetes Association has for the past six years sponsored and helped organize a continuous Nation-wide Diabetes Detection Drive. The Drive is an important part of the case-finding and health education program of the American Diabetes Association, and is sponsored and directly conducted by the medical profession working through local Medical Societies and affiliate Diabetes Associations, in coöperation with public-spirited lay groups in each community. Every year this Drive is renewed and inspired by a special proclaimed Diabetes Week. This year, the Seventh Annual Diabetes Detection Drive will be spearheaded by Diabetes Week, November 14–20. The Diabetes Association of the District of Columbia, an affiliate of the American Diabetes Association, will lead this Drive for the District of Columbia. Diabetes Week serves as a time for emphasis on a program which deserves continuing attention throughout the year.

WOMAN'S AUXILIARY NOTES

The Woman's Auxiliary to the Medical Society of the District of Columbia will begin the fiscal year 1954–55 with a meeting on October 13. Following are the new officers:

President: Mrs. Duane C. Richtmeyer
President-elect: Mrs. Lawrence A. Rapee
First Vice President: Mrs. J. Edward Morris
Second Vice President: Mrs. Leo C. Varden
Treasurer: Mrs. E. Herbert Bauersfeld
Assistant Treasurer: Mrs. Joseph M. Daly
Recording Secretary: Mrs. Vasilios S. Lambros
Assistant Recording Secretary: Mrs. Alec A. Preece
Corresponding Secretary: Mrs. Robert C. Haile
Assistant Corresponding Secretary: Mrs. Luther W. Gray

The first major activity of the Auxiliary will be in connection with the joint meeting of the District of Columbia and Virginia State Medical Societies on November 1, 2 and 3, at the Shoreham Hotel. Since early summer a committee, headed by Mrs. Rapee, has been meeting with members of the Woman's Auxiliary to the Medical Society of Virginia to assist them in planning for their convention, to be held at that time.

At the present time, six student nurses in three Washington hospitals are receiving full or partial nursing scholarships from the Auxiliary. This is the major philanthropic work of the Auxiliary, although each year donations are made to the Community Chest, Red Cross, Washington Heart Association, Tuberculosis Association, Cancer Clinic, *Today's Health*, and the American Medical Education Foundation.

MRS. DUANE C. RICHTMEYER
President, Woman's Auxiliary to the Medical Society of the District of Columbia

An interesting and varied series of programs for the Auxiliary meetings has been planned by Mrs. Hugh O. House, Chairman of the Program Committee. In December, new members will be welcomed at a tea in the Library of the Medical Society's Building.

On the Lighter Side

Now that the hunting season is upon us and the brown autumn fields are echoing to the barking of guns and the whirring of wings, there is a true story told in the doctor's lounging room of Columbia Hospital concerning three Medical Society members who went duck hunting one chilly fall day.

The place was a duck blind in the Wicomico River, southern Maryland. The scene—a blustery, gusty day with the wind whipping up the gray water into white froth on undulating swells that rose and fell with frightening regularity. The sun had lost its warmth and was dodging in and out from behind the leaden clouds. A winter chill penetrated the air.

The hunters had sighted the covey coming in low from the north, the birds barely skimming the water to find a quiet trough in which to settle and feed. Three guns exploded simultaneously again and again and again until the waves were speckled with floating ducks unable to fly again.

The river's tide was strong and running out to sea. The hunters looked with despair at those beautiful ducks bobbing up and down and floating farther and farther away from the duck blind. What to do! Well, one intrepid hunter, with the exuberance and boundless energy so characteristic of the man, jumped into the bobbing boat and pulled hard on the starter cord of the outboard motor. The engine sputtered, then finally whined into action as the hunter zoomed out into the choppy waters with spray flying to gather up the precious ducks. Most all of the floating birds that he was able to see from the boat were now safely stowed away. He shouted to the two hunters who had remained in the blind, "Are there any more?" Yes, there were more, and not too far away, but because of the undulant waves the boatman did not see them immediately. Now! he spotted the remaining bobbing carcasses and gunned the motor while trying to turn in a tight circle—but, alas, the boat shipped water on the turn, and, to the astonished eyes of the marooned hunters on the blind, slipped quietly under water out of sight with no more than a dying cough from the motor. The boatman had disappeared—shoes, boots, heavy clothing, equipment, ducks and all—under the murky waves. A cold, clammy, sinking sensation penetrated the chilled "innards" of the watching hunters as their eyes were focused on the watery spot under which their friend had disappeared. However, within a few seconds (although it seemed like hours to the watching companions), the boatman's head minus hat broke water followed by a furious splashing and thrashing as the thoroughly soaked swimmer tried to brave the ice cold waves in order to reach the upturned boat now slowly slipping out of reach with the tide. There was a sudden quick jerk of the boat's bow as the stern slowly swung around with the current, and it stopped moving as the anchor hit the bottom and held the upturned craft steady. The furious splashing and thrashing continued as the frantic, well-soaked swimmer valiantly tried to close the gap between himself and the safety of the boat. Finally, exhausted, he reached it, and clung with icy fingers to the slippery, sloping bottom.

"What'll I do now?" he gasped.

"Let your feet down and see if you can touch bottom," came back the shouted reply.

Slowly and gingerly the man overboard lowered his water-filled boots, and finally his groping toes touched sandy bottom. He lowered his soaked body and found that by standing on his tiptoes he could hold back his head and keep his chin above water. Thusly, succeeding in determining his position, the man overboard looked toward his companions and a big grin lighted up his once panic-strickened features.

Now that he was going to be all right and in no immediate danger of drowning, his confidence returned and he began the slow, tedious task of pushing in the upturned boat to the safety of the shore. There was no chance to salvage anything but himself and the boat, but as he reached shallower water he was able to go back a few feet for a duck or two that had been washed close to shore by the waves and wind. This he did with great flourish.

After the drying-out process of blazing fire and warming beverage had created comfort and conversation the man who had been overboard turned to his companions and with his usual impish grin asked, "What did you guys think when I went back after those two ducks?"

If you should run into Dr. Alec Preece or Dr. Frank Hodge ask them who was the hunter who made too tight a circle in a fast boat in choppy water, and was dunked in the drink for his trouble!

J. Earl Kadan, M.D.

News and Personals

MEETINGS—Past and Future

The Southern Medical Association is holding its **48th Annual Meeting** in St. Louis, the "home town" of its President, Dr. Alphonse McMahon, on November 8–11. Headquarters for the meeting is the Kiel Municipal Auditorium. Requests for room reservations for the meeting should be sent to the Housing Bureau, SMA, 911 Locust Street, Room 406, St. Louis 1, Missouri.

The 19th Annual Convention of the National Gastroenterological Association and the first **Convention of the American College of Gastroenterology** will be held at the Shoreham Hotel on October 25, 26, and 27, during the week preceding the First Interstate Scientific Assembly. This will be the last convention of the National Gastroenterological Association, whose fellowship have voted to become the American College of Gastroenterology. These scientific sessions will be open to all physicians without charge.

The Sixth Annual Course in Postgraduate Gastroenterology, under the personal direction of Dr. Owen H. Wangensteen, of Minneapolis, Minn., and Dr. I. Snapper, of Brooklyn, New York, will be given on October 28, 29 and 30, at the Shoreham and Walter Reed Army Hospital. Participating in giving the course will be a distinguished faculty from the various medical schools and the staff of Walter Reed Army Hospital. The Postgraduate Course will be open only to those who have matriculated in advance.

The Interim Scientific Session of the American Rheumatism Association will be held at the National Institute of Arthritis and Metabolic Diseases in Bethesda, Md., November 4. Physicians attending the First Interstate Scientific Assembly are invited to stay an extra day in order to attend this meeting. Dr. Darrell C. Crain is Chairman of the local Committee on Arrangements.

Dr. William P. Herbst wishes to announce the following dates and places of meeting for the **Urological X-ray Conferences,** of which there will be a total of nine, during the fall and winter months. The first was held on September 23 at the National Institutes of Health. Five others have been scheduled. They are:

October 21—D. C. General Hospital
November 18—Georgetown University Hospital
December 16—George Washington University Hospital
January 20—Freedmen's Hospital
February 17—National Institutes of Health

The meetings open at 8 p.m. All interested physicians are invited to attend. Dates for the final three meetings will be announced later.

The first of four 5-day **courses to be given by the Army Medical Service** during the present fiscal year on **"The Medical Care of Atomic Casualties"** was given in August at the Army Medical Service Graduate School, Walter Reed Army Medical Center. The other three courses will be presented on the following dates: October 25–30, January 10–15, and March 7–12.

The courses have the endorsement of the Secretary of the American Medical Association and the Secretary of the Council on Emergency Medical Service of the AMA. They are open to active duty professional officers of the component corps of the Army Medical Service and to medical service professional personnel of the Air Force, Navy, Public Health Service, Veterans Administration, and Civil Defense.

Army Medical Service personnel should submit applications to the Office of the Surgeon General, attention: Personnel Division, Career Management Branch. All others desiring to attend the course should direct their applications through their proper command or administrative channels.

Approximately 2,500 persons, representing 50 countries, registered for the **Second World Congress of Cardiology,** which was held at the National Guard Armory, September 12-17. Dr. Paul D. White, of Boston, President of the Congress, presided at the opening session.

A team of physicians from Georgetown University School of Medicine gave a clinical evaluation, September 14, of the first 42 patients with severe aortic insufficiency treated with a plastic aortic valve. They were Drs. Charles A. Hufnagel, W. Proctor Harvey, John T. Segal, R. Ari, and Pierre Rabil.

The 27th Annual Meeting of the Eastern Section of the American Trudeau Society was held in Washington, October 22 and 23, at the Sheraton-Park Hotel.

During the afternoon session, October 22, Dr. Sol Katz presented a paper on "Pleural Biopsy: A Preliminary Report." Dr. Katz is Chief Medical Officer, Pulmonary Disease Division, District of Columbia General Hospital, and is on the staff of both Georgetown and George Washington University Schools of Medicine. Dr. J. Winthrop Peabody, Jr. and Dr. Edgar W. Davis were co-authors of a paper on "Acquired Nonmalignant Esophagotracheobronchial Fistula" during the same session. Dr. Brian Blades, Professor of Surgery, George Washington University School of Medicine, was the first speaker in a panel discussion on "Pulmonary Emphysema," October 22.

Dr. Wallace M. Yater, Director of the Yater Clinic, was Chairman of the morning session, October 23, which was devoted to a discussion of "Surgery of Coronary Heart Disease."

Dr. Preston A. McLendon, President of the Medical Society of the District of Columbia, welcomed registrants for the **Seventh Annual Meeting of the American Association of Blood Banks** at its opening session, September 13, in behalf of the Medical Society.

Dr. Oscar B. Hunter, Jr., was Chairman of the Local Arrangements Committee and participated in the scientific program. A paper on "Coombs' Layering Test" was presented by him, with Nellie M. Bering, M. T., and Christabelle Lambert, M.T., as co-authors. Dr. Hunter was also co-author of a paper on "Cortisone Effect of Suppression of Antibody Responses," which was presented by Dr. W. G. Battaile, of the Doctors Hospital Research Foundation, and moderator of a luncheon panel discussion on "Public Relations."

Dr. William D. Dolan, an Associate member of the Medical Society, with Dr. Richard E. Palmer, of Arlington, Va., presented a paper on "Hemoglobin Evaluation Studies in a Community."

Drs. Jacob J. Weinstein, Joseph H. Roe and William C. Liu, of George Washington University School of Medicine and the District of Columbia General Hospital, presented a scientific exhibit on "Dextran for the Prevention and Treatment of Shock." The American Red Cross' exhibit on "Laboratory Fractionation of Blood" was credited to its Medical Director, Dr. David N. W. Grant, an Honorary member of the Society.

Three important meetings at the Shoreham Hotel, September 6-11, attracted some 1,400 pathologists to Washington. These were the **International Congress of Clinical Pathology, the International Conference of Geographical Pathology,** and a meeting of the **International Association of Medical Museums.**

Dr. Howard T. Karsner, Research Advisor to the Surgeon General of the Navy, represented the Navy's Bureau of Medicine and Surgery at these meetings. Dr. Karsner, who has been a member of the International Conference of Geographical Pathology since 1934, is President of the Conference as well as Chairman of the National Committee of the United States for the International Society of Geographical Pathology. He is an Associate member of the District Medical Society.

Dr. Karsner was chairman of a joint scientific session on the "Demography of Cancer," September 7. The same afternoon he was moderator for a panel discussion on "The Teaching of Pathology and Clinical Pathology to Undergraduate Students." He was also toastmaster for the closing banquet of the Congress and the Conference.

The 55th Annual Meeting of the American Roentgen Ray Society in Washington, September 20-24, was addressed by two members of the District Medical Society. Dr. Ralph M. Caulk, of Groover, Christie and Merritt, Senior Attending

Radiologist at Garfield Memorial Hospital, presented a paper, September 23, on "Review of 17 Years' Experience with Transvaginal Roentgen Therapy in Cervical Cancer." The report, covering the period from 1937 through 1953, gave results of X-ray treatment in more than 700 women treated for cancer of the cervix.

Dr. William B. Looney, of the U. S. Naval Hospital, an Associate member of the Society, reported on "A Study of the Late Effects Following Thorotrast Administration; the Clinical, Radiochemical, Autoradiographic, Histopathological, Roentgenographic and Physical Findings."

The following physicians will serve as officers of the **District Chapter of the American Academy of General Practice** for the year 1954–55:

Dr. Maurice J. Kossow, *President*; Dr. Samuel Diener, *Vice President*; Dr. Frank S. Pellegrini, *Secretary*; and Dr. C. Roger Kurtz, *Treasurer*.

GENERAL NEWS

The Executive Board of the Medical Society of the District of Columbia held a special meeting on September 10.

Dr. Daniel L. Borden and Dr. James A. Gannon were designated to receive the 1954 Certificates for Meritorious Service, which will be presented to them at the FIRST INTERSTATE SCIENTIFIC ASSEMBLY, November 2, in recognition of their outstanding contributions to their community both as physicians and citizens.

At the request of Dr. William Kurstin, President of the Diabetes Association and Chairman of the Diabetes Detection Week, the Board voted to endorse Diabetes Detection and Education Week, which will be held this year from November 14 to 20.

The Clinical Center of the National Institutes of Health announces that a special study is now being conducted on the anti-inflammatory effects of certain promising agents in acute carditis. Physicians in the Washington, D. C. area are invited to refer early cases of rheumatic fever at any age with unquestionable, acute involvement of the heart for treatment and study. Referrals of cases of disseminated lupus erythematosus in acute fulminating phase or those who are not responding satisfactorily to cortisone, hydrocortisone, or corticotropin also are invited. Please communicate with Dr. Joseph J. Bunim, Clinical Director, National Institute of Arthritis and Metabolic Diseases, Bethesda, Md.

The TV series, "The March of Medicine," again presented by the American Medical Association and sponsored by Smith, Kline & French Laboratories, will be resumed this fall, beginning Sunday, October 31, at 5:30 p.m. EST, over some 60 stations of the NBC television network. The première telecast will center on the subject of mental illness, focusing its attention primarily upon research and treatment advances in schizophrenia.

Physicians in the Medical Corps of the U. S. Navy, Naval Reserve officers, and veterans may secure a copy of Volume I of **"The History of the Medical Department of the United States Navy in World War II,"** without charge, by addressing a letter to Captain B. F. Avery, MC, USN, Director, Publications Division, Bureau of Medicine and Surgery, Navy Department, Washington, D. C. The physician should state his period of service and rank. The identifying number of the volume is NAVMED P-5031.

This narrative and pictorial book is printed on glossy paper and has a blue paper cover. The illustrations, 172 in number, will recall many familiar scenes to medical officers who served in the Navy in World War II. It may be had for the asking.

The new **George Washington University Cancer Clinic** received its first patients on Monday morning, September 13. The new building, which is called the Helen L. and Mary E. Warwick Memorial, has been under construction since October 1952. It will enable the Clinic's doctors to examine about 6,000 patients each year, about double the number cared for at the old clinic at 1339 H Street, N.W.

The building is constructed of Indiana limestone, built at a cost of $650,000, and is similar in design to the nearby Hospital. It will house facilities for cancer research, counseling, education of the public, and training of young doctors. It will include an auditorium for use in cancer education programs, a library, conference rooms, and an operating room for minor surgery; a room has also been set aside for meditation and religious services.

The fall convocation in Gaston Hall, September 12, marked the opening of the academic year of **Georgetown University School of Medicine.** Dr. Mario Mollari, Professor of Bacteriology and Immunology, gave the principal address; his subject was "Transition in Medical Education: the Future Outlook of Medicine."

Dr. Mollari was one of three Georgetown medical faculty members to receive the John J. Raskob Faculty Award from the Very Reverend Edward B. Dunn, S.J., President of the University. The others were: Dr. Charles A. Hufnagel, Director of the Experimental Surgery Laboratory, in recognition of his development of new surgical technics in the field of heart disease; and Dr. W. Proctor Harvey, Assistant Professor of Medicine, who was cited for his perfection of the tape recorder to allow medical students to become familiar with abnormal heart sounds.

On July 1, a new organization, to be known as the **Society of Pharmaceutical Representatives,** closed its charter membership with a total of 91 members, representing 41 ethical pharmaceutical manufacturers. According to the Constitution and By-laws of the Society, its purpose is to "promote a better interprofessional relationship between the pharmaceutical industry and pharmacy, medicine, and its allied professions" and "to continually foster a high standard of ethical and professional conduct on the part of Society members."

The following officers were elected on May 20:

Henry Mathews, Kensington, Md., *President*; Paul Schwarz, Takoma Park, Md., *First Vice President*; Robert Giffen, Bethesda, Md., *Second Vice President*; and Robert Hansen, Kensington, Md., *Secretary-Treasurer*.

PERSONALS

Dr. J. Ross Veal has been appointed by the District Commissioners to serve on their Public Welfare Advisory Council and was sworn into office, September 16. He will complete the term of Dr. Montgomery Blair, Jr., who resigned in July; the term expires August 15, 1956.

Dr. Veal, a graduate of the University of Pennsylvania School of Medicine, has been active for many years in both community and professional activities. He is Professor of Cardiovascular Surgery at Georgetown University School of Medicine. He was President of the Federation of Citizens' Associations in 1952, and is presently Chairman of the Health Section of United Community Services and Chairman of the Public Health Committee of the Washington Board of Trade.

Dr. Desmond S. O'Doherty has been appointed Director of the Muscular Dystrophy Clinic at Georgetown University Hospital, succeeding Dr. Tiffany Lawyer, who resigned to accept a clinical professorship in neurology at Columbia University and the directorship of the Montefiore Hospital Neurological Service in New York City.

Dr. O'Doherty, a graduate of Jefferson Medical College, has been on the staff of Georgetown for the past four years. He is Assistant Professor of Neurology and, before accepting the directorship of the Clinic, headed the Georgetown Neurological Service at the D. C. General Hospital. The Clinic is supported by the Washington Chapter of the Muscular Dystrophy Association.

Dr. Ruth Stocking has been appointed Director of Children's House at 4212 Nebraska Avenue, N.W. She had been serving as Acting Director of the District Health Department's Division of Mental Health in the absence of Dr. Leopold E. Wexberg, Director, who returned to duty on September 1.

Dr. Stocking, a graduate of the University of Chicago School of Medicine, is a diplomate of the Washington School of Psychiatry. She is on the staff of the Division of Neuropsychiatry of Howard University School of Medicine and has been consulting psychiatrist at Children's House for four years.

Children's House is one of three independent but coöperating agencies of the Hillcrest Children's

Center. It has day classes for emotionally disturbed and immature children, as well as after-school therapy classes for pupils of regular schools. Dr. Stocking estimated the enrollment at between 50 and 60 pupils.

Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, was the guest speaker, September 17, at a conference sponsored by the AMA and held at its headquarters in Chicago, September 17 and 18, for the purpose of creating closer working relationships between the family doctor, psychiatrists, and mental institutions in caring for mental patients.

Dr. Elmer Hess, President-elect of the AMA, gave the welcoming address. Dr. Leo H. Bartemeier, Chairman of the AMA's Committee on Mental Health, outlined the purposes of the meeting.

The second day of the meeting was devoted to ways in which the National Institute of Mental Health, the Council of State Governments, the American Psychiatric Association, and the AMA and its Woman's Auxiliary can coöperate in improving mental health.

Dr. James W. Watts attended the 19th Annual Congress of the United States and Canadian Sections, International College of Surgeons, at the Palmer House, Chicago, September 7–10. With Dr. Harold C. Voris, of Chicago, he presided at the afternoon session, September 8, of the Section on Neurosurgery.

The dedication banquet for the International Surgeons' Hall of Fame was a special feature of this Congress. One of the principal speakers at the banquet was Dr. Austin Smith, Editor of the *Journal of the AMA* and Executive Editor of the *World Medical Journal.*

Dr. Anna Bartsch-Dunne has established scholarships at the State University of Iowa, to be known as the Henry and Anna Bartsch Endowment, in memory of her parents. The funds will provide for an annual medical scholarship for a woman, also an annual medical internship for a woman, available to residents of Iowa. These scholarships are similar to the Anna Bartsch Endowment, established at George Washington University several years ago, in memory of her mother.

Dr. Daniel F. Lynch, oral surgeon, an Associate member of the District Medical Society since 1932, will take office as President of the American Dental Association, November 11, in Miami, Fla., during the 95th Annual Meeting of the Association.

Dr. Lynch, a former President of the District of Columbia Dental Society, has taken an active role in a movement to advance standards of dentistry throughout the world. He served as Vice President of the Federation Dentaire Internationale from 1947 to 1953 and was an official delegate to the International Dental Congresses in Vienna, Boston and London. He is a Fellow in Dental Surgery of the Royal College of Surgeons in England and holds honorary membership in dental societies throughout Central and South America, as well as those of Sweden and Norway.

DANIEL F. LYNCH, D.D.S.
President, American Dental Association, 1954–55

During the past 25 years, Dr. Lynch has, at various times, served as a part-time teacher at Georgetown University, George Washington University, and the University of Pennsylvania. He has also lectured on oral surgery and served as a consultant to the Army Medical Center and the Navy Dental School. In addition, he is a consultant to the U. S. Air Force, the Veterans Administration, the

U. S. Public Health Service, and St. Elizabeths Hospital.

During World War II, he saw active service as a Commander in the Navy Dental Corps and now holds a reserve commission. From 1949 to 1951 he was a member of the Armed Services Medical Adivisory Committee to the Department of Defense.

Dr. Irvin Hantman, Assistant Professor of Otorhinolaryngology, Georgetown University School of Medicine, has received an award from the American Academy of Ophthalmology and Otolaryngology for his work in perfecting a teaching aid, a large model of the human ear. Announcement of the award was made at the meeting of the Academy in New York, September 19-24.

Dr. Hantman recently completed a course in otorhinoplasty surgery at the Mount Sinai Hospital in New York City, given under the auspices of Columbia University.

Dr. June Carol Shafer, of Arlington, Va., was recently elected a member of the American Dermatological Association. Dr. Shafer is an alumna of the University of Wisconsin School of Medicine and is an Associate member of the District Medical Society.

Thodore Wiprud, Secretary, **and Lawrence A. Zupan,** Assistant Secretary, of the Medical Society of the District of Columbia, attended the AMA's third Medical Public Relations Institute, which was held at the Drake Hotel in Chicago, September 1 and 2. Mr. Wiprud, who is a member of the Public Relations Advisory Committee of the AMA, was moderator for a panel discussion the second day on "What's the Score on Fees?"

Dr. Jeanne C. Bateman presented a paper, September 6, before the meeting of the International College of Surgeons in Chicago at the Palmer House. The subject of her paper was "Palliation of Far Advanced Cancer with Triethylene Thio Phosphoramide."

Dr. Peter N. Lombard, of Silver Spring, Md., an Associate member of the D. C. Medical Society, has been appointed Chairman for the 1954 Christmas Seal Sale Campaign in Montgomery County.

Dr. Edward M. Pickford, Medical Director of the District Alcoholic Rehabilitation Center, **and Dr. Robert Gillman,** Director of the Arlington Mental Hygiene Clinic, took part in a series of lectures on how to handle abnormal persons, presented in September before trainees of Arlington's police force. The series was arranged by the Northern Virginia Mental Hygiene Society. Police officials of Alexandria, Falls Church and Fairfax also attended the lectures.

Dr. J. Raymond B. Hutchinson, of Arlington, Va., has been elected a member of the Board of Directors of the Acacia Mutual Life Insurance Company, to fill the unexpired term of the late Dr. John B. Nichols.

Dr. Hutchinson is a Vice President and Medical Director of Acacia. He is President of the Arlington County Medical Society, a member of the AMA and the Virginia Medical Society, and an Associate member of the District of Columbia Medical Society. He is a past chairman of the Medical Section of the American Life Convention and now is its secretary.

Three Active members of the District Medical Society have recently moved from Washington:

Dr. Edward J. Carry, whose office was at 1746 K Street, N. W., is now in El Centro, Calif., at 1511 Vine Street.

Dr. Kenneth R. Nelson, who was Director of the Washington Regional Blood Center, American Red Cross, from 1948 to 1954, is now in Salt Lake City, Utah. His address is 15 South Second East Street.

Dr. Marion B. Richmond has moved to 3928 Bryn Mawr Drive, Dallas 25, Texas, and is a member of the Dallas County Medical Society.

The following Associate members have moved away:

Dr. Thomas M. Arnett is now at 200 East State Street, Trenton, New Jersey.

Lt. Colonel Joseph W. Cooch, MC, USA, is presently on duty at the U. S. Army Hospital in Fort Dix, New Jersey.

Dr. Henry Rappaport has been appointed pathologist to Mount Sinai Hospital in Chicago.

Dr. J. Robert Teabeaut II has accepted an appointment in the Department of Pathology, University of Tennessee School of Medicine, Memphis, Tenn.

BOOK REVIEWS

The Physician and His Practice. Edited by Joseph Garland, M.D., Editor, *The New England Journal of Medicine.* Price, $5.00. Pp. 270. Boston: Little, 1954.

The editor states that this book "has been planned primarily as a source book of information regarding his (the physician's) career rather than as a detailed guide for the young doctor, who, his internship, residency, or military service completed, contemplates the fascinating fields that his training has laid open to him. It is a book that practitioners of longer standing may also find of value as they review their methods of practice, their material equipment, and the resources of the communities in which they live and work." As such it will provide illuminating information for physicians both old and young.

The book suffers somewhat from continuity, which characterizes books in which chapters are written by different contributors. Some of the chapters are so general in content, and so elementary, that it is doubtful if even the neophyte will find anything new in them. In contrast, there are such chapters as General Medicine, by Dr. Donald M. Clark, Group Practice, by Dr. Edwin P. Jordan, and others in which specific information is imparted for the guidance and enlightenment of physicians which is of unquestionable value.

All in all, this book is worthy of a place in every physician's library.

The Jealous Child. Edward Podolsky, M.D., Department of Psychiatry, Kings County Hospital, Brooklyn, New York. Price, $3.75. Pp. 147. New York: Philosophical Library, 1954.

Dr. Podolsky states in the foreword of this book that he has considered the various conditions which result in jealousy in a child and endeavors to point out what can be done for the jealous child.

This is generally true; however, the book seems to be a misnomer, probably so titled to catch the eye of a prospective reader. In reality it is a discussion of the mentally and physically handicapped child and how to handle him, described in a general fashion.

In chapters one and two, the growth and existence of the child in its environment are described. The causes of jealousy are briefly given in chapter three. The remainder of the chapters, which are brief, are discussions of various problems found in childhood, both physical and mental. These problems concern the adopted child, the unwanted child, and the diabetic child. General common-sense rules are listed as well as common-sense solutions for the various problems.

There is a good bibliography at the end of the book. The book is recommended for parents, teachers, and other professional people interested in these situations and their solution. Practicing physicians and medical students may find the book useful for refreshing their memories on the handling of these children.

Ira W. Pearlman, M.D.

The Allergic Child. Harry Swartz, M.D. Price, $3.95. Pp. 297. New York: Coward-McCann, 1954.

This book has been the subject of considerable comment in the recent press. It is described as a help and guide to parents, explaining the general problem of allergy in children.

It is true that it explains the general problem of allergy but on a very high plane. The book is theoretically directed to the layman and in actuality is very valuable to the physician who wishes to learn something of allergy in children. The layman who reads the book may be distressed or discouraged by the medical terminology. For this difficulty, there is an adequate glossary in the back of the book as well as an appendix giving the composition of various foods, listing of allergic drugs, and instructions for the maintenance of a dust-free room.

The first chapter is a philosophical one, describing the progression of the newborn to a human being through the maze of growing up and its pitfalls. The next six chapters discuss the nature of allergy and list the various types. The explanation is at the professional level and the descriptions are very satisfactory. The intelligent layman, too, should be able to grasp the factual material.

Chapters seven and eight discuss emotion and behavior problems. The views of Dr. Swartz are conservative in these matters and certainly have merit. The remainder of the book is concerned with nutrition, the handling and over-all treatment of the allergic child. The presentation generally is very good, making the book a worthwhile addition to the library of laymen and professional people interested in this problem.

The one omission that seems unfortunate is the absence of a bibliography to which interested readers might make further reference for additional reading.

Ira W. Pearlman, M.D.

Ciba Foundation Colloquia on Endocrinology. Volume V. Bioassay of Anterior Pituitary and Adrenocortical Hormones. G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., General Editor for the Ciba Foundation, assisted by Margaret P. Cameron, M.A., A.B.L.S. Price, $6.00. Pp. 228, with 53 illustrations. Volume VI. Hormonal Factors in Carbohydrate Metabolism. G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., General Editor for the Ciba Foundation, assisted by Jessie S. Freeman, M.B., B.S., D.P.H. Price, $6.75. Pp. 350, with 94 illustrations. Volume VII. Synthesis and Metabolism of Adrenocortical Steroids. W. KLYNE, M.A., B.SC., PH.D., Consulting Editor; G. E. W. WOLSTENHOLME, O.B.E., M.A., M.B., B.CH., AND MARGARET P. CAMERON, M.A., A.B.L.S., Editors for the Ciba Foundation. Price, $6.75. Pp. 297, with 375 structural formulæ and 29 illustrations. Boston: Little, 1953.

The three volumes reviewed constitute the latest publications of the 12 Colloquia on Endocrinology sponsored by the Ciba Foundation. These Colloquia are informal conferences in the field of biologic research. The proceedings are published with a minimum of editing and consist of brief papers (frequently on unpublished or uncompleted work) followed by free discussion by attending authorities. All three volumes are attractively bound and clearly printed; however, discussion of papers is recorded in distressingly small print, making reading difficult.

Volume V. Bioassay of Anterior Pituitary and Adrenocortical Hormones. The volume begins with a brief discussion of the requirements for chemically useful endocrine bioassays; ideally, these assays would be specific for the hormone being tested, reproducible, sensitive, simple, rapid, and inexpensive. The chapters which follow make it apparent that no bioassay under current study meets all these requirements. The first 162 pages deal with anterior pituitary hormone assay—thyrotrophic, gonadotrophins and prolactin, growth hormone, and adrenocorticotrophic hormone. Not all methods of bioassay currently under investigation are discussed, but both papers and discussion provide a good picture of the complex problems involved in the development of adequate bioassays.

The last 62 pages discuss adrenocortical hormones, their effect upon muscle work, and their methods of bioassay. An interesting chapter on the application of paper chromatography to assay problems is included. Assay methods for other hormones such as insulin or posterior pituitary extract are not discussed in this volume.

This book will be of interest primarily to the clinical endocrinologist or investigator in this field of research.

Volume VI. Hormonal Factors in Carbohydrate Metabolism. This information-packed volume presents papers and their discussion by authorities in the broad field of carbohydrate metabolism, as discussed under six general headings.

Part I deals with enzyme systems concerned in carbohydrate metabolism; there are complex chapters intelligible primarily to biochemists, and the reader may concur with Professor Charles H. Best, Chairman of the Colloquia, that it is "fairly rough going for those of us who are clinicians and physiologists." The following section discusses the interconversion of carbohydrate, protein and fat and their regulation by pituitary hormones, insulin and corticoids.

Parts III and V are of more interest to the clinician, discussing the influence of adrenal cortex on carbohydrate metabolism (including an interesting chapter on metabolism in obesity), and the influence of insulin on carbohydrate metabolism. The latter section, introduced by Dr. Best, presents studies on experimental and human diabetes, the pancreatic hyperglycemic factor, the response of the liver to insulin, and insulin-resistance in tissues. These are interesting chapters with obvious clinical application.

The closing section concerns sex hormones, pregnancy, and carbohydrate metabolism.

This volume is not easy reading; however, it is well worth the time spent in careful study for the interested clinician. Excellent references to key articles throughout the world literature are included.

Volume VII. Synthesis and Metabolism of Adrenocortical Steroids. This Colloquia presents an informative, technical review of developments in the rapidly expanding field of steroid chemistry and biochemistry. It is divided into two parts: Part I discusses the complicated research leading to the synthesis of adrenocortical and related compounds, including interesting historical anecdotes. Part II presents studies on the metabolism of adrenocortical steroids, both biogenesis and degradation in vitro and in vivo in man and experimental animals. Included in the book is a list of all known adrenal steroids and principal related steroids with comments on nomenclature.

The technical nature of this volume makes it of interest primarily to the steroid chemist and investigator in this field of research.

MARCUS SCHAAF, M.D.

BOOKS RECEIVED

Acknowledgment is made of the following books which have recently been received. Selections will be made for more extensive review in the interests of our readers and as space permits. Physicians are urged to submit reviews of additional current books which, in their opinion, merit comment.

The Physician and His Practice. Edited by JOSEPH GARLAND, M.D., Editor, *The New England Journal of Medicine*. Price, $5.00. Pp. 270. Boston: Little, 1954.

The Concept of Schizophrenia. W. F. MCAULEY, M.D., Belf., D.P.M., R.C.P.S.I., Principal Psychiatric Registrar, Downshire Hospital, Northern Ireland; Late Surgeon Lieutenant R.N.V.R. With a foreward by JOHN

H. Ewen, F.R.C.P., D.P.M., Formerly Physician and Lecturer in Psychological Medicine at the Westminster Hospital. Price, $3.75. Pp. 145. New York: Philosophical Library, 1954.

Practice of Allergy, 3rd ed. Warren T. Vaughan, M.D., Richmond, Virginia. Revised by J. Harvey Black, M.D., Dallas, Texas. Price, $21.00. Pp. 1164. St. Louis: Mosby, 1954.

A Ciba Foundation Symposium—Peripheral Circulation in Man. G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and J. S. Freeman, M.B., B.S., D.P.H., editors for the Ciba Foundation. Assisted by Joan Etherington. Price, $6.00. Pp. 219, with 72 illustrations. Boston: Little, 1954.

Fundamentals of Internal Medicine, 4th ed. Wallace Mason Yater, A.B., M.D., M.S. (in Med.), F.A.C.P., Director, Yater Clinic, Washington, D. C.; Formerly Professor of Medicine and Director of the Department of Medicine, Georgetown University School of Medicine; Physician-in-Chief, Georgetown University Hospital; Physician-in-Chief, Gallinger Municipal Hospital, Washington, D. C.; and Fellow in Medicine, Mayo Foundation, Rochester, Minnesota; with-21 contributors. This edition prepared with the assistance of William Francis Oliver, B.S., M.D., A.A.C.P. Staff Member, Department of Medicine, Santa Barbara Clinic; Consultant, Santa Barbara General Hospital; Attending Physician, Cottage Hospital; Attending Physician, St. Francis Hospital, Santa Barbara, California. Price, $13.50. Pp. 1276, illustrated. New York: Appleton, 1954.

ARTHUR JOSEPH HALL, M.D.

(1858–1954)

Dr. Arthur J. Hall, retired Washington physician, a Life member of the Medical Society of the District of Columbia, died, August 12, 1954, at the Masonic and Eastern Star Home, 6000 New Hampshire Avenue, N.E., where he had lived for 14 years. Prior to his death he was the oldest living member of the District Medical Society.

Dr. Hall was a native of St. Louis, Missouri, where he was born, March 7, 1858. He had resided in Washington since 1882. He graduated from George Washington University School of Medicine in 1886 and served as intern and resident physician at Emergency and Providence Hospitals.

From 1917 to 1919, during World War I, Dr. Hall served as Captain in the Army Medical Corps. He was at one time Acting Assistant Medical Director of the United States Public Health Service at the office of the immigration inspector, Newport News, Va.

Dr. Hall became a member of the District Medical Society in 1890 and of the Medical Association of the District of Columbia in 1891. He had been a Life member of the Society since 1931.

Surviving is a son, Coast Guard Admiral Arthur G. Hall, now stationed in New London, Conn.

HUGH JEFFERSON DAVIS, M.D.

(1889–1954)

Dr. Hugh J. Davis, Washington pediatrician for more than 30 years, who assumed the duties of Chief of the Medical Staff at Children's Hospital as recently as June, died suddenly, September 5, at his home, 3217 Cathedral Avenue, N.W. His offices were at 2721 Connecticut Avenue, N.W.

A native of Mississippi, Dr. Davis was born March 16, 1889, at Woodville, the son of Hugh L. and Laura McGehee Davis. He was a great nephew of Jefferson Davis, President of the Confederacy.

He received his early education at White's Preparatory School in Austin, Texas, and his medical degree from the University of Texas Medical School in Galveston in 1916. Following graduation he interned at St. Louis City Hospital and Philadelphia General Hospital before enlisting for service in the Army Medical Corps during World War I. As Captain in the Medical Corps, he served from 1917 to 1920.

Dr. Davis received training in his specialty, pediatrics, at Bellevue Hospital and Babies Hospital, New York City, in 1921 and 1922. Later in 1922 he began his practice in the District of Columbia.

Until his appointment as Chief of Staff at Children's in June, Dr. Davis was Vice Chairman of the Medical Staff. He became associated with Children's Hospital in 1922 and had been Attending Physician since 1931. He was consultant to the District Health Department's Bureau of Maternal and Child Welfare Service. Recently he was appointed international educational consultant for the Children's Bureau, Department of Health, Education and Welfare.

He became a member of the teaching staff of Georgetown University School of Medicine in 1928 and was Clinical Professor of Pediatrics from 1930 to 1946.

Dr. Davis was District Chairman of the American Academy of Pediatrics, a diplomate of the American Board of Pediatrics, and a member of the American Medical Association. Active membership in the District Medical Society began in 1923, and he had taken an active part in the Society, particularly in the work of the Committee on Child Welfare and the Section on Pediatrics, both of which he had served as Chairman.

He was a vestryman of St. Margaret's Episcopal Church. Social organizations of which he was a member included the Chevy Chase Club and Sigma Chi Fraternity.

Survivors are his wife, Mrs. Grace Douglas Davis, and six daughters: the Misses Laura M., Mary Ellen, Marguerite, and Patricia Davis, all of the home address; Mrs. Frank B. Williams, Alexandria, Va.; and Mrs. Robert R. Crowder, Jr., Mount Rainier, Md.

JORGE GUILLERMO RAMIREZ, B.S., M.D.

(1910–1954)

Dr. Jorge G. Ramirez, former Minister of Labor, Welfare and Public Health for the Government of Panama, and Washington ophthalmologist for the past four years, died, August 3, 1954, at Georgetown University Hospital. He was an Associate member of the District Medical Society.

Dr. Ramirez was born in Panama City, Panama, December 10, 1910, the son of Vicente H. and Rafaela D. Ramirez, who survive him. He received his early education in Panama City and his academic training at Georgetown University, receiving his Bachelor of Science degree in medicine in 1932 and his medical degree in 1934. He interned at St. Joseph's Hospital, Lancaster, Pa., the year following graduation and served as resident physician at Casualty Hospital, Washington, from 1935 to 1936. He took postgraduate study in ophthalmology at the Eye Institute of Presbyterian Hospital, New York, and at the Willis Eye Hospital in Philadelphia.

After his residency training in the States, Dr. Ramirez returned to Panama City. He was affiliated with Santo Tomas Hospital from 1936 to 1949, where he was Chief of the Clinic and later Head of the Department of Ophthalmology.

In 1948–49 he served Panama as its Minister of Labor, Public Health and Social Welfare. He was a member of the Constituent Assembly of Panama which gave the Central American country its third constitution in 1946.

In 1950 he returned to Washington to engage in the private practice of ophthalmology, maintaining his office at 1779 Massachusetts Avenue, N.W. Since 1952 he had been on the staff of George Washington University School of Medicine as Clinical Instructor in Ophthalmology. He was on the visiting staff of George Washington and Casualty Hospitals.

Pending fulfillment of United States citizenship requirements, Dr. Ramirez became an Associate member of the District Medical Society in 1952. He was Past President and Past Secretary of the National Medical Association of Panama, and a member of the Pan-American Association of Ophthalmology, the Cuban Ophthalmological Society, Habana, and the Pan-American Medical Society, Washington.

Besides his parents, he leaves his wife, Mrs. Margaret Lyon Ramirez, and a son, Jorge Mitchell Ramirez, living at their home, 2419 Chain Bridge Road, N.W.; a sister, Miss Anita Ramirez, who is counselor at the Panama Embassy, and a second sister, Mrs. Mildred Ramirez-Duque, of Panama City.

Food Allergy—Bernton

(*Continued from page 554*)

Two modern contrivances, the thermos bottle and the electric percolator, solve the problem. The thermos bottle on the bedside table will provide a drink for those who prefer hot water. Those who enjoy their morning coffee may have it while in bed through the use of a simple expedient. A few minutes of preparation the night before will minimize the discomforts of a much longer period the following morning. A tray holds in readiness the percolator filled with water, the coffee is added, the current is turned on.

Aroma, warmth, and triumph over seeming difficulties make the beginning of the day a propitious one, even for the allergic patient.

In 1868, 86 years ago, Henry Hyde Salter of the English School made the following noteworthy comment: "Asthma is doubly capricious, the disease in general is capricious and each case is capricious in itself." The same holds true of food allergy as of this date.

Neuroses Following Trauma—Laughlin

(*Continued from page 580*)

elsewhere in the United States, as well as a few in other countries who have critically reviewed various sections of the material. I would especially like to express my appreciation for the valuable editorial contributions and personal assistance of Dr. Wallace M. Yater, Editor, and Miss A. Louise Eckburg, Assistant Editor, of the Medical Annals of the District of Columbia.

6800 Hillcrest Place
Chevy Chase 15, Maryland

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MEDICAL SOCIETIES WITH LIMITED MEMBERSHIP

WASHINGTON, D. C.

1954–1955

SOCIETY	PRESIDENT	SECRETARY	NO. MEETINGS PER YEAR	DATE OF MEETINGS	PLACE OF MEETINGS
American Academy of General Practice, D.C. Chapter	M. J. Kossow	F. S. Pellegrini	4	3rd Tuesday, Oct., Dec., Feb., Apr.	MSDC Building
Baltimore-Washington Dermatological	J. Q. Gant	J. L. Derzavis	8	3rd Thursday	Alternating Cities
Clinical Club of Washington	E. C. Wilson, Jr.	B. G. Brown	8	2nd Tuesday	Army-Navy Club
Clinical Society of Diabetes Association	S. D. Loube	A. G. Saidman	4	On Call	Homes or MSDC Bldg.
Clinico-Pathological	B. L. Hardin	W. M. Willett	8	3rd Tuesday	Homes
Diabetes Association	S. W. Kirstein	L. K. Alpert		On Call	MSDC Bldg.
Georgetown Clinical	K. C. Corley	F. L. Zinzi	7	3rd Tuesday	Hotel 2400
Georgetown University Medical Alumni Club	R. A. Osbourn	W. D. Dolan	1	On Call	
George Washington University	L. C. Stevenson	W. O. Bailey, Jr.	8	3rd Wednesday	MSDC Building
Harvard Medical Alumni	S. Ross	F. G. MacMurray	1	On Call	
Hippocrates-Galen	E. E. Ferguson	R. G. Klepser	5	1st Thursday, Nov., Jan., Feb., Mar., Apr.	
International Medical Club	C. P. King	P. S. Constantinople		On Call	Mayflower Hotel
Jacobi	C. G. Aronstein	W. Lewis	8	3rd Monday	Washington Hotel
Kober	G. H. McAteer	J. E. Morris	7	3rd Monday	Army-Navy Club
Louis Mackall	W. L. Howell	M. N. Stow	8	3rd Thursday	Kennedy-Warren
Medical Arts	J. H. Peacock	G. E. Schreiner	7	2nd Thursday	Kennedy-Warren
Metropolitan Health Officers Association	D. L. Seckinger	R. G. Beachley	4	On Call	Washington Golf &CountryClub
Osler	F. S. Rogers	F. D. Chapman	8	4th Monday	Homes
Pan American (D.C. Branch)	A. F. Castro	D. F. Lynch	4	Mar., May, Oct., Dec.	Shoreham & Mayflower Hotels
Physician-Veterans of World War II	F. S. Ashburn	E. A. Gould	1	December 7	
Providence Hospital Doctors Alumni Association	E. S. Pellegrini	T. F. Curtin	10	3rd Sunday	Providence Hospital
Rheumatism	E. B. Carr	I. Levin	3	Nov., Feb., June	Old New Orleans Restaurant
St. Elizabeths Hospital	J. L. Hoffman	D. W. Harris	3 or 4	Fall, Winter, Spring	St. Elizabeths Hospital & MSDC Bldg.
Society of Anesthesiologists	R. R. Cross	W. H. Devlin	4	Oct. 11, Nov. 29, Jan. 31, May 9	MSDC Building
Washington Academy of Medicine	H. L. Darner	E. C. Albritton	3	Fall, Winter, Spring	Roger-Smith Hotel

NOTE: Most of these societies begin their meetings in October and continue through April or May.

MEDICAL SOCIETIES WITH LIMITED MEMBERSHIP—*Continued*

SOCIETY	PRESIDENT	SECRETARY	NO. MEETINGS PER YEAR	DATE OF MEETINGS	PLACE OF MEETINGS
Washington Academy of Surgery	W. R. Morris	D. C. Richtmeyer	4	2nd Monday, Oct., Dec., Feb., Apr.	Kennedy-Warren
Washington Gynecological	R. T. Holden	J. A. Dusbabek	5	Oct. 30, Dec., Jan., Mar., May	Willard Hotel
Washington Heart Association, Scientific Council	J. A. Reisinger	Mrs. C. T. Clagett	4	On Call	
Washington Medical and Surgical	E. J. C. Hildenbrand	J. P. Hand, Jr.	6	4th Monday, Oct.–Apr., except Dec.	Hotel 2400
Washington Orthopedic Club	A. B. Rohrbaugh, Jr.	H. W. Jeagers	8	1st Monday	George Washington Hospital
Washington Psychiatric	D. Noble	S. J. Rosenberg	8	2nd Friday	MSDC Bldg.
Washington Psychoanalytic	M. T. Cohen	S. L. Olinick	8	On Call	1720 M St., N. W.
Washington Society of Pathologists	C. H. Binford	J. S. Howe	8	Oct. 7, Nov. 5, Dec. 6, Jan. 4, Feb. 2, Mar. 3, Apr. 1, May 7	Army Medical Service Graduate School, Walter Reed
Washington Urological	G. Ottenberg	G. R. Gable	6	Every 6 weeks	Doctors Hospital
Women's Medical	M. K. L. Sartwell	A. J. Speer	7	1st Tuesday	MSDC Building or Doctors Hospital

SECTIONS OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

1954–1955

SECTION	CHAIRMAN	SECRETARY	NO. MEETINGS PER YEAR	DATE OF MEETINGS	PLACE OF MEETINGS
Anesthesiology	R. R. Cross	W. H. Devlin	4	Oct. 11, Nov. 29, Jan. 31, May 9	MSDC Building
Dermatology and Syphilology	R. Stolar	N. M. Kanof	2	On Call	MSDC Building
Gastroenterology	W. T. Gibb	M. Mensh	5	1st Monday	Homes
General Practice	I. P. Frohman	W. R. Perkins, Jr.	4	4th Tuesday, Oct., Jan., Mar., May	MSDC Building
Neurology and Psychiatry	H. H. Ammerman	S. L. Rollins, Jr.	8	1st Thursday	MSDC Bldg.
Ophthalmology	R. L. Norment	R. E. duPrey	4	2nd Tuesday, every other month	Kennedy-Warren
Otolaryngology	W. B. Walters	R. S. Page, Jr.	5	3rd Tuesday, Oct., Nov., Jan., Mar., May	Army-Navy Club
Pathology and Laboratory Medicine	J. E. Ash	E. C. McGarry	9	Last Friday	Homes
Pediatrics	G. Maksim	J. E. Cassidy		On Call	Children's Hospital
Radiology	K. C. Corley	J. A. Long	4	3rd Wednesday, Oct., Jan., Mar., May	MSDC Building

MEDICAL ANNALS
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CONGENITAL ANOMALIES OF THE ESOPHAGUS*

MICHAEL K. KURILLA, M.D.
Trenton, New Jersey

IN THE last few decades there have been great advances in all of the fields of medicine. The most widely known, perhaps, are insulin, vitamins, chemotherapy, antibiotics, fluid and electrolyte balance, hormone therapy, and the many and varied laboratory discoveries. With all of these we should turn our attention to some of the advances which have been made in the field of pediatric surgery, and one should be reminded that although these have been aided by laboratory discoveries they would have been impossible without the coöperation on the part of the pediatrician and the general practitioner.

Some 30 years ago atresia of the bile ducts carried a mortality of 100 per cent. Intestinal obstruction due to midgut volvulus had an equally high mortality. Congenital diaphragmatic hernias, other than those through the esophageal hiatus, had an estimated mortality of 90 per cent. The recovery of a patient with intestinal atresia was indeed a rare incident. The mortality from intussusception, and even from pyloric stenosis, was close to 60 per cent.

In direct contrast, today the mortality in these and other conditions has been reduced by from 25 to 75 per cent, and in some conditions to nearly zero. One hundred per cent recoveries never will be possible because of the associated anomalies, prematurity, poor condition of some of the patients, aspiration pneumonia, and the all too infrequent establishment of the diagnosis. This dramatic decrease in mortality can be attributed directly to those men and women, both medical and surgical, who have devoted and continue to devote their energies to the care of infants and children. By working together and with one goal in mind, namely, the improvement of the lot of the afflicted child, one may assume an optimistic outlook, with greater advances being made in the decades to come.

This condition was described by Gibson in 1703,[1] but it was not until 1939 that the first successful repairs were reported by Leven and Ladd. Before that time many unsuccessful attempts to correct this anomaly were made by many surgeons with different plans of approach. These attempts added to the knowledge of conditions which might be expected and paved the way for later successful results. Ladd maintains that three fundamental conditions were essential in mastering this problem.

First, the surgeon should have not only a delicate and refined technic but also a thorough knowledge of the variations of the anomalies which he may find and a plan for meeting them. He must also be accustomed to operating on small infants and use suitably sized instruments, needles, and suture material. He must likewise be familiar with the preoperative and postoperative care, including the fluid and feeding requirements of infants who undergo major surgical operations. In his team there should be an expert anesthetist for infants and an assistant with facility in isolating small veins of infants for intravenous transfusion, medication and fluids, as indicated.

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Second, early diagnosis and appreciation of the fact that infants at two or three days of life stand major surgical procedures far better than at the end of a week or later. This is particularly important in the cases of esophageal atresia, since infants with this condition usually develop aspiration pneumonia soon after birth, thereby diminishing the prognosis daily. The surgeon is at the mercy of the obstetrician, pediatrician, or general practitioner for this early diagnosis, and if they fail him a high mortality will result, no matter how good his operative technic may be.

Embryological Data

Third, some knowledge of embryology is helpful in understanding the variations of esophageal atresia and tracheo-esophageal fistula, and as stricture and duplications of the esophagus are really only variations of the same arrest in development, these anomalies will also be mentioned.

Congenital anomalies of the esophagus are defects which are present at birth. Lay persons have long ascribed them to a multitude of natural and supernatural prenatal influences, and the medical profession, hampered by the difficulties of observing human fetal development in utero, has long ascribed them to defective inheritance and has adopted a fatalistic attitude toward them. Studies in human teratology until recently have been confined largely to descriptions of frequencies and morphologies. Congenital malformations, as an unhappy result, have remained unchanged in incidence while fetal and infant morbidity and mortality due to many other causes have declined.

It has been estimated by Sir G. Gray Turner[2] that the congenital anomalies of the esophagus occur about once in every 2,500 births or approximately about the same frequency as harelip and cleft palate. If this estimate be accurate it suggests that we are less acute in our diagnostic ability than we should be. In considering this point, Belsey and Donnison[3] suggested that more of these cases are misdiagnosed than was previously assumed and that the actual incidence is about 1 case in about every 800 births. It is known that the esophagus is developed from the first part of the primitive gut, its upper part from the retropharyngeal segment and the lower part from the pregastric segment. In the beginning the trachea and esophagus are one tube, as in fishes, but in the process of development become separated or pinched apart by the ingrowth of muscle and connective tissue. At first, it is a short tube extending from the pharynx to the stomach. However, as the neck differentiates and the heart and lungs push the stomach caudad, the esophagus elongates rapidly.

Between the third and twelfth week of fetal life great changes take place in the embryo and with amazing rapidity. During the fourth week the laryngotracheal groove develops to become the larynx and trachea and the primordia of the lungs. Two furrows course longitudinally along the sides of this respiratory primordium and cut inward and deeper until they separate it from the esophagus. This separation, contrary to the general rule, progresses in a cephalic direction with the result that the lung bud is the first to become free.

In embryos of 6 weeks the epithelium has acquired 2 layers of cells. One to 2 weeks later the epithelium thickens by proliferation, whereupon vacuoles appear in it and increase the size of the lumen. In this way the lining becomes irregularly channeled, but at no time is it totally occluded like the fetal esophagus of various other vertebrates.

The partial epithelial occlusion, normally a transient feature, predisposes toward all of these anomalies. An arrest of this process or an incomplete separation leaves the 2 tubes connected with the resultant tracheo-esophageal fistula. The furrowing or pinching off process may take place transversely as well as sagittally, causing the esophagus to end as a blind pouch or a stricture, in case the pinching off is incomplete. Also, it is to be remembered that at this time the lumen of the esophagus becomes obliterated by epithelial concrescence, resulting in an almost solid cord in place of a tube. As the esophagus lengthens, the cord becomes vacuolated, the vacuoles coalesce, and the lumen is reëstablished. A failure of these vacuoles to coalesce sagittally could result in atresia of the esophagus by a velum or, if this velum is perforated by a small hole, in stricture or stenosis. Failure of the vacuoles to coalesce transversely will result in a duplication, and according to how much this development is combined with the pinching off process will depend what tissue lies between the duplication and the esophagus. There may be nothing but mucous membrane between the 2 or there may be also muscle and connective tissue, or in some instances they may be completely separated with a space between.

At birth the epithelium numbers 10 layers and includes some ciliated cells. Superficial glands are developed in the fourth month, but the deep glands arise much later. As a constituent of the mediastinum, the esophagus never acquires a typical mesentery. The average measurements of the esophagus, according to Mitchell and Nelson,[4] are given in table 1.

According to Ladd,[5] the anomalies mentioned may be divided into 5 types (see also figure 1):

Type 1. The upper esophageal segment terminates in a blind pouch in its upper one third, and the lower esophageal segment is represented by a similar blind pouch. There is no communication with the trachea.

Type 2. The upper esophageal segment communicates with the trachea, and the lower esophageal segment consists of a blind pouch.

Type 3. The upper esophageal segment terminates blindly, while the lower esophageal segment communicates with the trachea above the carina.

TABLE 1

*Average Measurements of the Esophagus**

AGE	TEETH TO CRICOID	TEETH TO BIFURCATION	TEETH TO CARDIA
Birth	7 cm.	12 cm.	18 cm.
1 year	9 cm.	14 cm.	21 cm.
3 years	10 cm.	16 cm.	23 cm.
5 years	11 cm.	17 cm.	25 cm.
10 years	12 cm.	19 cm.	29 cm.
15 years	14 cm.	23 cm.	33 cm.
Adult	16 cm.	25 cm.	40 cm.

* From Mitchell and Nelson[4]

Type 4. This is similar to type 3 with the exception that the lower esophageal segment communicates with the trachea at the carina or with a main stem bronchus.

Type 5. Both the upper and lower esophageal segments communicate with the trachea.

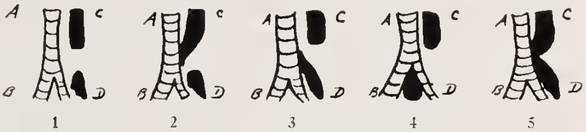

FIG. 1. Five types of esophageal anomalies (from Ladd[5]).

A—trachea; B—bifurcation; C—upper segment of esophagus; D—lower segment of esophagus.

The simplest form of the anomaly, type 1, constitutes about 3 per cent of the cases. In the commonest form of the anomaly, a tracheo-esophageal fistula is associated with the atresia, and in 94 per cent of the cases this communicates with the lower esophageal segment. In these patients the upper esophagus ends in a blind pouch at the level of the second or third thoracic vertebra. In rare instances a fistula may go to the upper esophageal segment or there may be a double fistula, one to the upper and one to the lower esophageal segment. A tracheo-esophageal fistula may also be present without an atresia.

These last 3 types are rare, each occurring in about 1 per cent of the cases. Esophageal atresia with tracheo-esophageal fistula is a congenital anomaly which is incompatible with life unless corrected early.

Clinical Features

Such a defect is to be suspected if the newborn baby shows a symptom-complex consisting of the three "c's," namely, coughing, choking, and cyanosis. This is especially true if there is an abnormal amount of drooling and rhinorrhea with or without cyanosis. These symptoms should suggest an impending surgical emergency. The chest examination may give signs of atelectasis, rales or pneumonia, most commonly in the right upper lobe. The abdomen may become distended and tympanitic after a few hours if the lower segment of the esophagus has a fistulous connection with the trachea. On the other hand, if there is no such connection with the trachea, one will find a scaphoid and non-tympanitic abdomen. It is rare to find the first sign to be pneumonia or atelectasis. In the newborn in which there is excessive mucus in the mouth and throat the diagnosis should be considered, and the regurgitation of feedings immediately after swallowing, in association with coughing and cyanosis, is almost pathognomonic. This mucus may be bile-stained due to the presence of the tracheo-esophageal fistula and may be a source of confusion in establishing the diagnosis.

When the infant regurgitates almost immediately the first fluid given, one's suspicions should be increased, and a soft rubber catheter (no. 8 F or no. 10 F) should be introduced into the esophagus. If this meets with obstruction 10 to 12 cm. from the lips, the diagnosis is confirmed. The obstruction is usually met at the level of the third or fourth thoracic vertebra. It is well to consider doing the examination under a fluoroscope, since there is always the possibility for the catheter to curl back on itself in the blind pouch without giving any sense of resistance during its passage. With the rubber catheter in place all mucus and retained secretions should be aspirated from the blind pouch in order to prevent further spill over into the lungs. At this point it is very important to determine the type of esophageal obstruction and the presence or absence of a tracheal fistula. About 1 c.c. of lipiodol is introduced through the catheter and outlines the lower limit of the blind pouch. If there is a fistula between the upper segment of the esophagus and the trachea, this can be demonstrated by the roentgenogram. The roentgenogram will also show whether or not air is present in the stomach, which will demonstrate whether or not there is a fistulous tract between the lower segment of the esophagus and the trachea. Care should be exercised in not using too much lipiodol, since it may fill the bronchi, either through a fistula or by regurgitation and aspiration, thereby confusing the picture. At no time should barium be used, since it will get into the lungs and cause chemical pneumonitis or add to the already existent pneumonia and will mechanically block off many of the smaller bronchi.

The diagnosis of tracheo-esophageal fistula without atresia is not so easy and may be difficult to confirm by either roentgenogram or esophagoscopy. Ladd[6] relates a case of respiratory difficulty after feeding, in which the presence of a fistula was suspected, but he refrained from operating because of the inability to demonstrate the fistula by either roentgenogram or esophagoscopy. At post mortem a small fistula was found, and the opinion at that time was that it could have been remedied rather easily.

In these cases it is important to consider the presence of other anomalies and associated conditions that tend to complicate the picture. One must always consider the possibility of multiple anomalies, some of which are incompatible with life. In 35 cases analyzed by Potts,[7] he found that 9 weighed less than 5 pounds, and these patients all died. Pless reported 94 cases of tracheo-esophageal fistula, in whom 59 had associated anomalies. In 24 of these cases, imperforate anus was found to be the associated anomaly. The anomalies and associated conditions are listed in table 2.

TABLE 2

Anomalies and Complicating Associated Conditions

1. Prematurity
2. Imperforate anus
3. Pneumonia and/or atelectasis
4. Underweight (prognosis altered by weight)
5. Cardiovascular anomalies
6. Small bowel atresia
7. Subdural hematomas (unsuspected)
8. Genitourinary tract anomalies
9. Brain tumor
10. Facial paralysis
11. Cleft palate and harelip
12. Deformity of ear
13. Hypertrophic pyloric stenosis

The urgency of making the diagnosis of congenital esophageal stricture is not so great, as even a small opening will take care of the constant flow of saliva and some of the feeding for a week or 10 days. The occurrence of aspiration pneumonia though frequent is not uniform. Regurgitation immediately after feeding is the cardinal symptom and becomes more pronounced as the amount of the feeding is increased. The roentgenogram of the esophagus containing lipiodol readily confirms the diagnosis. These strictures are easily confused with a narrowing of the esophagus from spasm due to other causes rather than the arrest in embryologic development previously described.

Duplications of the esophagus are far more difficult to diagnose than the other anomalies of the esophagus. The symptoms are very variable and may not appear for several weeks, or even months, until the size of the cyst has gradually increased by the secretion of its mucous lining. Then the symptoms may be due to pressure causing respiratory difficulty, hemoptysis, recurrent attacks of respiratory infection, or poor development. Occasionally, the cyst may be discovered accidentally in the course of examination of the child who has presented no symptoms referable to the duplication. The physical signs also may be variable and may be masked by the intercurrent pulmonary infection. However, on physical examination of the chest one may find in the back the classical signs of fluid, associated with a displaced heart. The roentgenogram may demonstrate a spherical mass of uniform density with a characteristically smooth outline. The roentgenogram may also show that this mass is retropleural and of course will demonstrate cardiac displacement if existent.

TREATMENT

After the diagnosis is made, the next important step is that of preoperative care. The patient should be prepared as rapidly as possible for the operation. This period of treatment should be short and efficiently organized so that no time is wasted and the patient is ready for operation within a few hours. In essence, this phase is aimed at preventing further aspiration, combating the existing pneumonia, and establishing the proper fluid and electrolyte balance. All these points are realized in the following manner. Since these children usually have some degree of respiratory embarrassment because of aspirated saliva and mucus, they should be placed in a slight Trendelenburg position and a catheter inserted into the proximal esophageal segment. Two extra holes should be cut in the catheter so that there will be efficient removal of material from the esophageal pouch. The catheter is then subjected to gentle but constant suction. This is felt to be the single, most important step in all of the preoperative management. The slight Trendelenburg position is proposed by Ladd,[8] while Sanford[9] prefers an elevated head position since it prevents the regurgitation of intestinal secretions through the fistula.

In combating infection suitable antibiotics or chemotherapy should be employed. Penicillin has been an important adjunct in lowering the mortality, but streptomycin has been found to be of greater value since 1947.

Since these infants are usually dehydrated, 5 per cent dextrose in water is given intravenously. A few hours after admission, a red blood count is done and, if found to be over 4.5 million, plasma is given; or if below this level, a transfusion should be administered. Caution should be exercised with this or parenteral fluids in order to avoid amounts sufficient to cause pulmonary edema. The total amount of fluid given through a vein at one time should be calculated on the basis of 10 c.c. per pound of body weight. One or two such intravenous injections should be given preoperatively. In establishing and maintaining the fluid and electrolyte balance it is extremely important to restrict the intake of salt, because these patients can become edematous, and this state is hazardous from the standpoint of surgery and also in the postoperative management.

In addition to these there are several other minor points in the preoperative management that should be employed. Needless to say, however, nothing should be administered by mouth. Facilities should be available in administering oxygen by means of an oxygen tent. In order to achieve all this, it is imperative that constant, special nursing care be available. The patient should be kept on the side to be operated on or on the side in which the inflammatory process is most marked, thereby tending to limit it to this area.

Preoperative medication with morphine may lead to serious periods of apnea during cyclopropane anesthesia and therefore should not be used in these cases. It is desirable to give atropine preoperatively, 0.06 mg. being given subcutaneously, in order to reduce secretions. A constant intravenous needle should be in place before the operation begins, and during the procedure blood should be given slowly to keep the infant in good condition.

As soon as the above preparations have been completed the operations should be performed, since needless delay will increase the mortality greatly. Within 24 hours or less there will be considerable improvement in the general condition of the patient. The temperature will approach normal, and respirations and pulse rate will become slower. Delays in operating beyond 24 to 36 hours will be to no avail, since the danger of further aspiration pneumonia will more than outweigh any possible gain.

Probably the most important factor of anesthesia is a good anesthetist with extensive experience in anesthetizing infants. Next in importance is the selection of the type of anesthesia and the method of giving it. The selection of the anesthesia is said to be a matter of individual preference, but most feel that cyclopropane or ether in a closed system with oxygen available is the most satisfactory. Theoretically, the use of intratracheal anesthesia should be the most desirable, but this method has been associated with a higher mortality rate than when a simple, tight-fitting mask and closed system are used. In comparison to local anesthesia, cyclopropane has the advantage of shortening the procedure and of saving the patient a great deal of energy.

The first successful operations were performed in multiple stages by Leven and Ladd in 1939. The first stage consisted of exposing the esophagus and trachea retropleurally through the right side of the back and obliterating the tracheo-esophageal fistula. A day or two later, the second stage was done, which consisted of bringing the upper segment of the esophagus to the skin over the left clavicle and also doing a gastrostomy. This prevented any further aspiration of saliva and mucus and regurgitation of the gastric contents to the lung. It also made provision for adequate feedings. The next steps consisted of connecting the esophagus to the intestinal tract. This was done by bringing a loop of jejunum anterior to the thoracic cage and anastomosing it directly to the esophagus or with a connecting link of skin tube. By use of this Ladd has 16 surviving children, leading quite normal lives. However, this plan has many disadvantages, such as many operations and long hospitalizations. With increased experience the direct anastomosis of the two segments of esophagus has become more feasible and has supplanted the earlier plan. The first successful primary end-to-end anastomosis was performed by Cameron Haight[10] in 1943.

For the direct anastomosis, this approach may be made in the same way retropleurally through the right side of the back. Both retropleural and intrapleural approach on both right or left sides have been used, but the one that has proven most satisfactory consists of a right retropleural approach, with the infant lying on the left side and either the major portion of the third or fourth rib resected, or short segments of the second, third, and fourth ribs removed. A small retractor is then introduced, and the intercostal muscle bundles are divided if necessary. The lung is now gently mobilized anteriorly and medially. At this point the upper esophageal segment is seen to be greatly thickened and dilated. This is due to futile attempts at swallowing during the last weeks of intrauterine life. The lower esophageal segment is seen as a small and thin-walled structure. The tracheo-esophageal fistula is identified, excised, and closed as soon as possible in order to prevent regurgitation from the stomach or distention resulting from pumping anesthetic gases into the intestinal tract. The upper esophageal segment is then freed for as great a distance into the neck as possible. Since the blood supply to the lower esophageal segment is not so abundant, it is wise to limit its dissection. If both ends can be approximated without undue tension, a careful end-to-end anastomosis should be done with 2 layers of interrupted silk sutures in order to avoid stricture. Some surgeons advocate telescoping the lower segment into the larger upper segment to insure a more snug anastomosis.

Passing an esophageal tube through the anastomosis at the time the suture is being applied will simplify and aid the procedure. After this procedure has been completed, it is important to draw the esophageal tube proximal to the suture line.

Before suturing the incision in the thoracic cage and skin, it is wise to put in either a small multiperforated catheter or small rubber tissue drain, making sure that it is carried down to the region of the anastomosis and brought to the outside through a small separate stab wound. If a small catheter is employed, it should be attached to a water-seal suction apparatus. Both skin incisions should be closed likewise with interrupted sutures.

Twenty-four to 48 hours following the mediastinal exploration a gastrostomy should be performed. Some maintain that local anesthesia is quite satisfactory for the procedure while others advocate cyclopropane. Bigger[11] advocates doing the gastrostomy prior to the repair of the fistula and esophageal atresia because this method helps to deflate the intestinal tract and so prevents regurgitation of the intestinal contents into the bronchial tree when gentle suction is employed. Others believe that it is dangerous to begin feedings prior to the closing of the fistula and maintain that gastrostomy should follow the primary repair.

In a certain number of cases, estimated as 1 in 15, the upper and lower esophageal segments cannot be approximated without undue tension; or in some of the cases in which agenesis of the lower esophageal segment exists, primary union cannot be accomplished. In these types of cases the fistula is closed and the upper esophageal segment is brought out in the neck as a cervical fistula. The lower esophageal segment is closed and a gastrostomy performed. The continuity of the intestinal tract is established later by one of several methods. The multiple stage, skin-tube esophagoplasties are to be condemned because of their frequent failures, multiple procedures, long hospitalizations, and poor cosmetic results.

There is a variance of opinion as to the best method of relieving congenital esophageal stricture. In selecting the form of treatment one should consider the lesion and recall that it offers a very different problem from the lye-produced stricture seen in older children.

The 4 plans that have been recommended as means of relieving congenital esophageal stricture are:

1. Dilation through the esophagoscope. This method is dangerous except in the most expert hands and then not as effective as other methods.

2. Dilation with a bougie and string guide.

This has the disadvantage of the difficulty of getting the string down without a gastrostomy and also is not without danger on account of the stiffness of the dilators.

3. Excision of the stricture with end-to-end anastomosis. This is a formidable operation to be resorted to only with special indications.

4. Retrograde bougienage with the sausage-shaped pliable rubber bougies introduced through a gastrostomy. This type of treatment has several advantages. The infant may be put and kept in good health by gastrostomy feedings. The bougies are pulled, not pushed; they are flexible so that they can follow the curve of the esophagus and large enough to be effective. It is the safest and surest method in most cases.

Duplications of the esophagus present difficulties not only of diagnosis but also of treatment. Complete excision is the operation of choice when feasible and when the duplication is completely separated from the esophagus. However, if one will recall the embryology, some cases are not completely separated from the esophagus but are closely fused with it, with no lines of cleavage between the duplication and the esophagus. In those cases in which there may be only two layers of mucous membrane between the duplication and the esophagus, it is almost impossible not to injure the esophagus with resultant leakage and fatal termination, or the development of postoperative stricture. This situation has been successfully overcome by excising as much of the duplication as can be done safely and marsupializing the rest to the skin in back. The remainder of the mucous lining may then be destroyed by sclerosing and gauze packs.

Precise postoperative care of these patients is of the utmost importance. The infant is placed in an oxygen tent and given transfusions and parenteral fluids for the first 48 hours or so. The infants all have a certain amount of pneumonia which can usually be fairly well controlled by antibiotics and chemotherapy.

Generalized edema is a common and serious postoperative complication. Therefore, all infants should be weighed daily to determine the amount of edema that may be developing. The healing of the chest wound and, more important, of the anastomosis of the esophagus is delayed in the presence of any edema. To help prevent this complication, precaution must be taken against giving excess fluids to these infants. As long as a baby voids 4 to 5 times in a 24-hour period, an adequate fluid intake is being supplied. Care must also be exercised against the administration of excess chlorides, which may be responsible for the accumulation of the edema fluids.

Another factor contributing to the postoperative edema is failure to supply an adequate protein intake. These infants are in need of protein because (1) the infection which they all have to some degree causes a loss in their protein reserve; (2) it is well known that the process of healing after an extensive operation requires large amounts of protein; and (3) these infants are on a starvation regimen before and for a time after operation. Accordingly, every effort must be directed toward a high protein and caloric intake in the early postoperative period.

At this point in the course of the patient's therapy, a gastrostomy is performed. Every precaution must be taken to prevent retching and vomiting as this places a strain on the anastomosis. The feedings are given in small amounts and slowly, usually by the drop method, which can be done quite readily through the gastrostomy tube. The rate of giving the feeding can be dropped so as to allow 30 to 45 minutes for each feeding. It is desirable to begin gastrostomy feedings early, and a 6-hour delay is safe, but most authors believe that they should be initiated no earlier than 8 hours following the procedure. In 24 hours a dilute formula is given through the tube, and in 48 hours a full strength formula is supplied.

Until adequate gastrostomy feedings are possible, blood and plasma should be given each day. If edema is marked, concentrated human albumin is given in amounts of from 5 to 8 c.c. intravenously daily. As the amounts of the feedings are increased, of course, the amount of parenteral fluids can be decreased. The rate of administration of intravenous fluids should not exceed 2 c.c. per minute. It is a great temptation to pump them in rapidly, but it must be remembered that the rate of injection a normal infant will tolerate is no criterion in the treatment of these infants, particularly those with edema and pulmonary infection. Rapid injection might initiate overwhelming pulmonary edema.

The patients should be started on small amounts of fluid by mouth on the seventh to tenth postoperative day if there are no complications. Usually in 4 to 5 days thereafter all of the formula can be taken orally and at which time the gastrostomy tube may be removed. In the occasional case of a very rugged infant in whom an exceptionally satisfactory anastomosis has been possible, the gastrostomy step can be omitted. Most of the cases are discharged on the sixteenth postoperative day. A very small percentage of the patients require dilation. Swenson[12] had only 2 out of 57 surviving patients requiring dilation, and none of the remaining had any difficulty in swallowing. It is advised to delay solid foods at least to the sixth month.

Of the 32 primary anastomoses in Swenson's series[12] there were only 5 postoperative deaths. He attributes the low mortality rate to the following factors: (1) earlier diagnosis, in consequence of which the infants are sent into the hospital before an overwhelming pneumonia develops, (2) improved preoperative as well as postoperative care, and (3) changes in operative technic.

Sanford[9] feels that the increased mortality in these cases can be attributed to the following common factors: (1) suspecting the diagnosis late, (2) passing a catheter blindly without the aid of fluoroscopy, which may allow it to curl up in the blind pouch or pass through the trachea into the stomach by way of the tracheo-esophageal fistula, (3) failure to aspirate the upper segment of the esophagus, thus allowing further aspiration of mucus or oil once it is instilled, (4) the use of too much lipiodol, allowing some to spill over into the trachea, (5) the use of barium, with its irritative properties, instead of lipiodol, (6) failure to restrict saline intake, thereby causing peripheral and pulmonary edema, (7) delay in operation with the hope that the baby will become stronger, or refusing to operate once pneumonia is present, (8) failure to attempt a primary anastomosis or fanatical determination to perform one even in the presence of too much tension on the suture lines, and (9) failure to consider the possibility of multiple anomalies.

Conclusion

It can be stated that esophageal atresia with tracheo-esophageal fistula still remains a serious congenital anomaly but is now amenable to surgery. There have been many problems in the history of overcoming this condition, of which the greater majority have been met with considerable success. It has been shown that through further coöperation on the part of the general practitioner, pediatrician and surgeon, greater achievements can be obtained in this very delicate and difficult field of medicine. When there is a realization by all those concerned of the many yet to be obtained possibilities, then and only then will there be an almost complete eradication of this congenital anomaly.

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PEPTIC ESOPHAGITIS AND PEPTIC ULCER OF THE ESOPHAGUS

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THE patient with peptic ulceration of the lower esophagus has for a long time suffered his ulcer in a sort of 'no-man's land' to which the abdominal surgeon could not reach and to which the physician had no access. The radiologist passed by as quickly as the force of swallowing would take him. The endoscopist saw it as through a glass darkly on the distant boundary of his territory but was glad to withdraw to more familiar territory." Thus in 1948 did Allison[1] give the status of peptic ulcer of the esophagus.

Such a 'no-man's land' is not justified, considering the long period that esophagitis and ulcer have been known. Inflammation of the esophagus was originally described by Galen. In 1722 Boehm published an account of the disease and thus reintroduced the entity to the medical profession. In 1785 Bleuland gave a forceful description of the disease since he himself was a victim.[2] Benjamin Rush in 1808, in describing the last illness of William Shippen, noted that Shippen was distressed with a "soreness in his esophagus which rendered swallowing painful."[3] John Peter Frank in 1822 also described the disease and suggested the term "esophagitis".[2] Albers in 1839 was the first accurately to describe ulcer of the esophagus and compare it to peptic ulcer of the stomach or duodenum.[4] Tilleston[4] in 1906 collected 40 cases of esophageal ulcer from the literature, and in 1929 Jackson[5] was able to report 88 personal cases of esophageal ulcer.

Albeit that the history is long, the pathologic process is still little understood and definitive treatment poorly defined. This last is especially true in regard to surgical therapy.

ETIOLOGY

"Reflux esophagitis"[6] is a term coined by Allison[1] in 1948 and expresses the opinion of Tilleston[4] in 1906, "In order that peptic ulcer should be formed, it is evidently necessary that the cardia should be insufficient, allowing regurgitation of the gastric juice into the esophagus."

Hiatal hernia is the most common mechanism which causes incompetence of the cardiac sphincter mechanism. Such incompetence allows reflux of gastric juice. The continued presence of the juice leads to esophagitis, digestion of the esophagus and resultant ulceration. Allison[1] was the first to point out to us that this process often leads to what was formerly described as the "congenitally short" esophagus. Actually this latter condition may start with an esophagus of normal length associated with a sliding hiatal hernia and hence incompetence of the cardiac sphincter. Reflux of gastric juice causes esophagitis and ulcer. Fibrotic shortening of the esophagus occurs following healing of the ulcer. When stenosis and fibrosis have occurred the condition is permanent.

Surgical destruction of the cardiac mechanism is caused by resection of the cardia with esophagogastrostomy or cardioplasty. Ripley, Olsen and Kirklin[7] studied such patients at the Mayo Clinic. In the period of 1936 to 1950 they were able to follow adequately 65 patients who had had such surgery. Of this group "28 subsequently had positive signs and 12 subsequently had presumptive signs of peptic esophagitis or formation of a stricture." Barrett and Franklin[8] report 25 patients who had similar surgery for achalasia of the esophagus. Sixteen of the 19 patients treated by esophagogastrostomy and 4 of the 6 patients treated by cardioplasty developed esophagitis.

It is well recognized that incompetence of the cardia (patulous cardia[9-13]) may occur in individuals without hiatal hernia. Feldman[10] states that incompetence of the cardio-esophageal opening occurs in 7.5 per cent of cases examined by means of X-rays. Such incompetence is seen in patients with and without organic pathology. Lawler and McCreath[12] report 56 cases of "gastro-esophageal regurgitation." They were able to demonstrate a hiatal hernia in only 34 patients. Such a state will easily and repeatedly bathe the esophagus with acid juice. It could well be as important as hiatal hernia as a cause of esophagitis. It is intriguing to speculate that the patulous hiatus is due to poor approximation of the crura of the diaphragm. A hiatal hernia would not be present if the stomach is held in an abdominal position by competent phreno-esophageal ligaments. Whether or not a hernia is actually present, the result is the same—flooding of the lower esophagus with gastric juice. This mechanism would then explain "idiopathic" stricture of the esophagus. The next step in the speculation is whether or not surgery with reapproximation of the crura would correct the esophagitis and prevent stricture formation.

"Congenitally short esophagus" is still recognized as a clinical entity. However, many cases formerly classified under this group are now recognized as usually normal length esophagi associated with hiatal hernia. Since the cardia of the stomach is in the thorax, there is an incompetent cardiac sphincter. Regurgitation of gastric juice with resultant esophagitis occurs.

The extension of gastric mucosa into the esophagus or islands of aberrant gastric glands in the esophagus has been known for years (aberrant or heterotopic gastric mucosa).[14-19] Apparently Schmidt in Germany was the first to report such an occurrence in 1805.[17] Taylor,[18] in a study of 81 cases of epithelial heterotopias of the alimentary tract, found 6 instances of gastric mucosa in the esophagus. Rector and Connerley[17] in the course of 1,000 consecutive autopsies took random specimens from the upper, middle and lower thirds of the esophagus. In 78 cases they found gastric mucosa. Interestingly enough, the ectopic mucosa was mostly found in the upper third of the esophagus (51 per cent).

All authors agree that aberrant gastric mucosa does exist. The argument commences when the significance of its presence is discussed. Most authors believe that the secretion of acid juice by such islands could cause ulceration.[13, 20-22] Barrett[23] and Wandall[24] doubt whether such small areas could secrete sufficient acid to be of significance. The experiences of the Minnesota group[20, 21] would seem to prove conclusively that gastric juice has a marked destructive action on the esophagus and also that transplanted islands of gastric mucosa are perfectly capable of causing esophageal ulcer. Such ulceration even occurred in cases in which the acid-bearing portion of the stomach is removed at the time of transplantation of an island of gastric mucosa into the esophagus.

Repeated vomiting as in vomiting of pregnancy,[25] prolonged use of Levine tubes,[26] and gallbladder disease are all thought to play a role in some cases of esophagitis and esophageal ulcer.

Lawler and McCreath[12] examined cases of heartburn of pregnancy and found that the vast majority showed "massive regurgitation" whether or not a hiatal hernia was present.

INCIDENCE

Esophagitis has been described as the most common disease of the esophagus.[25] Wangensteen[27] has stated, "It may appear that, next to duodenal ulcer, esophagitis is the next most frequent variety of ulcer, exceeding gastric ulcer in frequency." In 1948 Allison[1] discussed a personal experience with 74 cases of peptic ulcer of the esophagus mainly associated with hiatal hernia. Palmer[28] has stated that 2 per cent of all people who undergo esophagoscopy have a peptic ulcer of the esophagus.

Males are somewhat more commonly afflicted.[1, 4, 28, 29] The age at onset varies from infancy to the eighties. However, the majority were in the fifth and sixth decade.[1, 28, 30]

SYMPTOMS[5, 28, 30-32]

Pain is the most common and most persistent complaint. It may be substernal or located high in the epigastrium. It is often more noted on an empty stomach and is relieved by alkalies. When ulcer, rather than esophagitis, is present the pain occurs on swallowing. In some patients the pain penetrates to the back. Patients frequently notice a relation to posture, the pain occurring or being aggravated by assuming the supine position. The milder type of pain is often described by the patient as heartburn.

Dysphagia occurs in a large proportion of cases, in 90 per cent of Allison's series.[1] It occurs in all stages of the process: esophagitis, ulcer and also stenosis.

Vomiting is more frequent in children. It is often self-induced in adults in an attempt to obtain relief.

Regurgitation should be separated from vomiting. One patient described this feature well when he stated that he had to swallow his meals twice. Allison[1] has labeled this phenomenon "rumination" to describe regurgitation of food from the stomach without vomiting. If the patient lies down or leans forward, food is present in the pharynx. The ease with which this is done is described by one patient in the literature. This lady could swallow a piece of toffee, sing a hymn, and then at her leisure bring the toffee up and eat it.[33]

"The constancy of the symptoms, with only short and variable periods of relief, is a feature of great importance."[12] Such constancy aids in distinguishing this condition from peptic ulcer of the stomach or duodenum.

DIAGNOSIS

In addition to the symptoms mentioned above, the diagnosis rests on esophagoscopy and X-ray examination. Esophagoscopy is the more accurate method.[5, 24, 28, 33, 34] By means of it leukoplakia may be observed. Ulcers surrounded by a thickened mucosa may be seen. They are usually covered with a fibrinopurulent membrane. When this membrane is removed, the base of the ulcer bleeds easily. In patients with hiatal hernia, the cardiac orifice is met at a higher level than normally. Stenosis when present is due to inflammation and repair about the ulcer. The stenosis may actually prevent visualization of the ulcer. With ulceration it may be extremely difficult to rule out carcinoma by inspection alone. In the presence of benign stricture, Allison[1] and Wandall[24] both stress the occurrence of discrete superficial ulcers for several centimeters above the stricture and acute congestion of the mucosa. Biopsy, which may have to be repeated, will rule out most cases of suspected carcinoma. In the remainder, a thoracotomy will be necessary to completely eliminate the diagnosis of carcinoma.

X-ray examination[10, 12, 30, 33, 35-37] is valuable but not as satisfactory. With the barium swallow, superficial esophagitis is difficult or impossible to discover. More advanced esophagitis is diagnosed by narrowing of the walls with an irregular appearance of mucosal stenosis. When present, it is of 2 types, (1) long and smooth, and (2) irregular. The latter variety causes confusion with carcinoma. The actual ulcer often is not seen.

A search for a hiatal hernia should be made. The customary method of examination is to fill the stomach with barium, place the patient in the Trendelenburg position and apply pressure to the abdominal wall. The British radiologists are partial to lateral fluoroscopy while the patient touches his toes.

It should be remembered that esophagitis and ulcer will not occur in the para-esophageal variety of hiatal hernia. This statement is true, since the angle of entry of the esophagus into the stomach is not changed and regurgitation of gastric juice does not occur.

In some patients a patulous cardia without herniation will be noted on X-ray examination. Reflux of barium into the esophagus will occur. Feldman[10] states that this occurs in 8 per cent of people examined. Lawler and McCreath[12] note that "Regurgitation has not been observed in normal persons, but only in patients with characteristic symptoms of esophagitis."

ASSOCIATED DISEASE[27-30, 34, 38, 39]

The frequent association of hiatal hernia has already been noted. A certain number of patients also have gastric or duodenal ulcers. Benedict and Sweet[29] report 6 patients who had combinations of hiatal hernia, duodenal ulcer and esophageal ulcer. Palmer[28] states that 25 per cent of patients with esophageal ulcer will have peptic ulcer elsewhere. The incidence of alcoholics in this group is significant.[29, 30, 38]

COMPLICATIONS[1, 9, 25, 28, 29, 32, 40-43]

Complications are like those of peptic ulcer elsewhere—hemorrhage, perforation, intractable pain and obstruction. Carcinoma should also be included under this heading. These complications constitute the indications for surgery.

Vinson and Butt[25] state that hemorrhage is the second most common symptom of esophagitis. Allison[1] recorded bleeding in 11 of a group of 74 patients. Ten of these patients bled severely. Holinger and Johnston[32] state that bleeding occurs in 50 per cent of cases. If the source is unrecognized, hemorrhage may be fatal. Mellins[41] has pointed out that it is a common cause of hematemesis in infants.

Perforation is a dread complication which may terminate fatally and has been stated to occur in 14 per cent of cases of peptic ulcer of esophagus.[9]

Perforation may be into the mediastinum, the pleural cavity or, as pointed out by Coffey[15] and Dawson,[35] into the abdomen. In the presence of prolonged vomiting or severe pain in a patient with esophageal ulcer the physician should consider the possibility and search for pleural effusion and subcutaneous emphysema.

Obstruction by stricture is common in both the acute and also in the healed state. In the acute phase, it is due to spasm; in the healed phase it is due to fibrosis following repair. It may respond to dilation, but the more severe forms will require extirpative surgery.

Benedict and Sweet[29] report carcinoma as a complication in a patient with the combination of hiatal hernia, duodenal and esophageal ulcers.

TREATMENT[9, 27-29, 30, 32, 33, 39, 44, 45]

The therapy may be conveniently classified as to medical and surgical. The ulcer is first treated as peptic ulcers elsewhere. Bland diet is advised. Antacids and atropine are prescribed. Alcohol and tobacco are forbidden. Since the reflux is the problem, the patient is advised to maintain the upright position. When sleeping, the head of the bed should be elevated.

With healing of the ulcer and resultant stricture, instrumental dilation will frequently adequately treat the stricture. This is especially true in the earlier cases associated with a hiatal hernia, when repair of the hernia will lead to healing of ulcer. However, the procedure is not without hazard. Sweet et al[46] record 21 patients who received dilations by bougienage. The procedure was accompanied by hemorrhage in 7 and perforation in another.

Two statements are worth quoting: "The rational treatment is to cure the deformity which allows acid to reach the esophagus."[1] "Once the mucous membrane is completely destroyed around the entire circumference of the esophagus, the improvement resulting from dilation is transitory, and surgical measures must be employed."[46]

When there is an associated hiatal hernia the treatment is obvious, transthoracic repair of hiatal hernia. It should be realized that in many so-called "congenitally short" esophagi the primary defect is a hiatal hernia. With repair of the hernia the cardia can be brought easily below the diaphragm. Transthoracic repair of hiatal hernia will lead to ulcer cure since the cardia will now function normally and thus prevent regurgitation of acid gastric contents. In some patients repair of the hernia will have to be followed by dilations to treat the stenosis caused by the healing ulcer.

Esophagoplasty is recommended by Benedict and Sweet[29] for short strictured areas. The operation consists of longitudinal incision of the strictured area and transverse closure. Benedict and Sweet report excellent results in the 3 patients when this operation was used. Sweet et al[46] have pointed out that such a procedure is of advantage in the aged. The obvious objection to such a procedure is that it does nothing to correct the original cause of the ulcer, reflux of acid gastric contents.

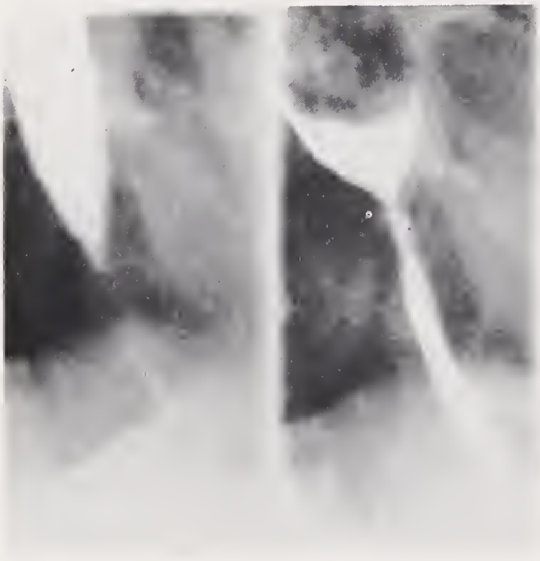

Fig. 1. Case J. W. Preoperative barium swallow demonstrating ulcer formation.

Esophagogastrostomy is a side-to-side anastomosis of the stomach and esophagus without resection of the esophagus.[44] The surgery is planned to by-pass the stricture. Here again the cause of the stricture is not removed.

Subtotal gastric resection has been strongly advocated because gastric acidity is reduced and gastric emptying time is shortened.[9, 27] Such an operation may well be effective when a hiatal hernia is not present but a duodenal ulcer is. Concomitant structure of the esophagus is treated by dilation.

Vagotomy combined with gastro-enterostomy is recommended by Palmer[28] in cases in which hiatal hernia or stricture do not exist. In his opinion, it is a superior procedure to subtotal gastric resection. Allison[1] has objected to the procedure since he has seen esophageal ulcer form following vagotomy for gastric ulcer.

Excision on partial resection of esophagus and stomach consists in resection of the strictured area of the esophagus, partial resection of the stomach, and esophagogastrostomy. Benedict and Sweet[29] stress the need to get well above the proximal portion of the stricture. It would also seem wise to resect the major portion of the stomach so that the acid-bearing portion is removed. In discussing this operation, Allison[1] recommends esophagojejunostomy so as to prevent reflux and possible recurrence of the ulcer. Either variety of anastomosis has been attended by a high percentage of successful results.[29, 33] Wilson[30] in 1951 reported that 34 such resections with esophagogastrostomy have been performed. Thirty-one patients survived the procedure and 30 had excellent results.

The following case illustrates the value of surgical treatment after conservative treatment has failed.

J.W. was a 37-year-old colored man. He was first seen in 1952 at the Providence Hospital Medical Clinic. He gave a history of 15 months of dysphagia. A barium swallow was reported as showing narrowing of the lower third of the esophagus (figure 1). The patient received esophageal dilation with what he described as poor results. He was seen again in December, 1953. He had never been free of symptoms and had subsisted on a soft diet plus antacid therapy. One month prior to entry the symptoms had become aggravated so that his diet was limited to clear liquids, ice cream and dilute puddings. Substernal pain was a prominent complaint. He had lost 18 pounds in weight.

Barium studies revealed "a spindle-like dilatation of the distal one third of esophagus followed by constriction. There is noted a small outpouching at the anterior wall of the esophagus suggestive of an ulcer."

The past history revealed bilateral pulmonary tuberculosis in 1942, which was treated by 14 months of sanatorium care.

The patient was esophagoscoped. At 35 cm. from the incisor teeth there was a nearly complete obstruction. The area was inflamed with shallow ulceration. The area did not look malignant. A biopsy was taken which was later reported as inflammatory tissue.

In view of the long history, poor response to dilation, obstruction and evidence of active ulceration, resectional surgery was considered advisable. On December 30, 1953 a transthoracic resection of the lower esophagus and stomach was performed. The esophageal hiatus easily admitted 4 fingers, a fact which may have etiologic significance. The lower 8 cm. of the esophagus showed acute and chronic inflammatory changes. The phrenic nerve was crushed. The lower 8 cm. of the esophagus and 60 per cent of the stomach were removed and a esophagogastrostomy performed. The pathologist's report was chronic ulcer of the lower esophagus. The postoperative course was benign. The highest postoperative temperature was 99.8°F. The patient took water on the second postoperative day, clear liquids on the following day, and a soft diet on the fourth day. Two thoracenteses were necessary.

The patient is now on a diet of 4 meals a day. He returned to work 1 month after surgery.

SUMMARY

Peptic ulcer of the esophagus is a common condition. It is due to the continued presence of gastric juice in the lower esophagus. The cause of the presence of gastric juice may be an incompetent cardiac sphincter on aberrant islands of gastric tissue in esophagus.

The symptoms include pain, dysphagia and regurgitation of food. Males are more commonly affected. The diagnosis can be verified by esophagoscopy and barium X-ray examination.

The complications are those of peptic ulcer elsewhere, pain, hemorrhage, perforation, and obstruction. Surgery is indicated for the complications. Resection of the involved area is often necessary. Combined with an adequate resection of the stomach, such surgery gives good results.

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(Continued on page 664)

EXPERIENCE WITH A TUBELESS METHOD OF GASTRIC ANALYSIS

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UNTIL recently, studies of gastric physiology have been hindered by the difficulties inherent in the intubation method of obtaining specimens.[1]

The tubeless method of determining free gastric HCl was reported by Segal et al.[2] This consists of the oral administration of a cation-exchange-quinine-indicator mixture and the subsequent determination of urinary quinine at intervals. When this resinous compound with its attached quininium ion contacts dilute acids, the hydrogen ion displaces the quininium from the resin. If free gastric HCl is present, quininium is released and excreted by the kidneys.

The objects of this study were (1) to evaluate the efficacy and accuracy of a tubeless method for gastric analysis, and (2) to investigate the effect of upper intestinal secretions other than gastric HCl on the test substance.

Material and Methods

Clinical study. The method of Segal as described by Malach and Banks[3] was used. Fifty subjects were tested with Diagnex Granules (Squibb), each test packet containing 2 Gm. of a cation exchange resin (Amberlite XE-96, Rohm and Haas, Philadelphia) upon which 36 mg. of quinine are adsorbed.

Each subject was required to be without food, except for water, from the midnight before the test. The morning urine was discarded, and 250 mg. caffeine sodium benzoate with one-half glass of water was administered. Fifty c.c. of 7 per cent ethyl alcohol, or 0.5 c.c. of histamine hydrochloride, subcutaneously, may be used in place of caffeine to stimulate HCl secretion by the parietal cells. An hour later urine was voided, saved as a control, and Diagnex Granules was given in a glass of water. At 1- and 2-hour intervals thereafter urines were collected and saved. In this study the control and 1-hour specimens were not analyzed. The 2-hour specimen was assumed to be critical. The laboratory procedure is as follows:

The total volume of the 2-hour specimen is diluted to 300 c.c. with distilled water, and 35 c.c. of diluted urine is placed in a separatory funnel with 0.5 c.c. 1 N NaOH and 15 c.c. C.P. ethyl ether. This is gently shaken a few times and the layers allowed to separate. The ether (containing quinine) will be on top, the urine below. The 50.5 c.c. in the funnel is run off to the 8 c.c. mark, leaving only ether in the funnel. Five c.c. of 0.1 N H_2SO_4 are added to the ether and gently shaken. The quinine (as quinine sulfate) is now in the lower sulfuric acid level. This is run off into a small test tube, and under ultraviolet light the turbidity of this unknown is compared to 2 standards, made by dissolving quinine sulfate in normal urine.[4, 5] The dilutions of these standards are adjusted to contain 15 and 25 mcg. quinine sulfate per c.c. If the unknown is more turbid than the 25 mcg. standard, it is read as "positive" for free acid. If less than the 15 mcg. standard, it is "negative," and between the 2 is a "trace" (see figures 1 and 2).†

In vitro enzyme study. To determine whether or not salivary, gastric, and upper intestinal enzymes elute quinine from the test substance,

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† Readings of less than 15 mcg. are interpreted as negative since they represent extremely small quantities of free HCl.

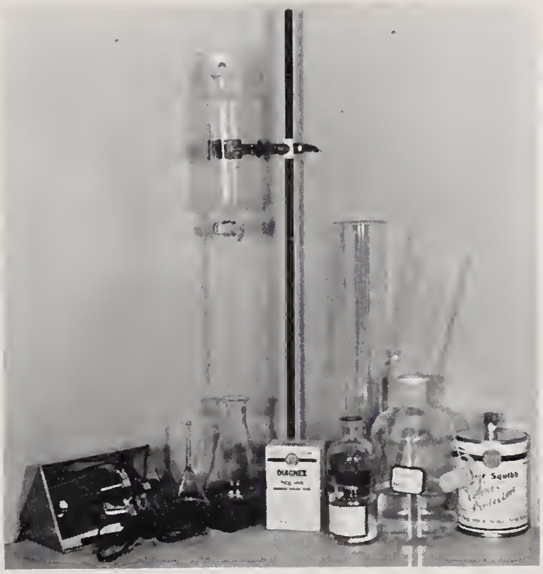

FIG. 1. Necessary laboratory materials for determination of gastric acidity without intubation.

pure saturated solutions of these enzymes were incubated with Diagnex Granules for 2 hours at 37°C. Controls were run without Granules to compare the degree of turbidity. At the end of 2 hours the supernatant was filtered off and divided into halves, 1 of which was read directly under ultraviolet light. The other portion of filtrate was handled as a clinical unknown.

RESULTS

Clinical study (tables 1 and 2). Of the 50 subjects, 41 were white and 30 were males. Seven were normal medical students, and 9 were cancer patients. In the control study on 14 subjects (28 per cent of total) there was a positive correlation between the tube and tubeless method in 12 (86 per cent of the controls). One subject was negative by tube and positive by tubeless. Another was positive by tube and gave a trace reading by tubeless.

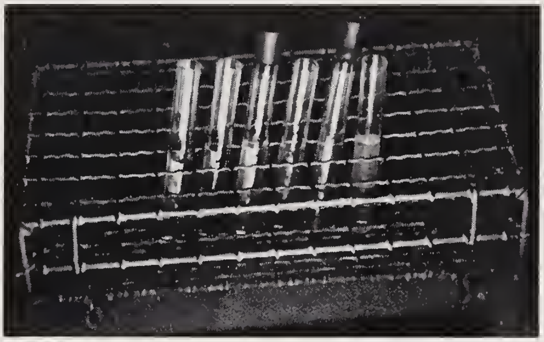

FIG. 2. Standards and unknowns set up for reading under ultraviolet light.

In the tubeless study (50 subjects) 20 were positive, 18 were negative, and 12 were trace. One half of the negatives were older than 50, and

TABLE 1
Control Study

CASE NO.	AGE	RACE	SEX	DIAGNOSIS	TUBE	TUBELESS	COMMENTS
1.	25	W	M	Normal	Pos.	Pos.	
2.	48	W	F	Possible cancer of stomach	Pos.	Pos.	
3.	75	W	F	G.I. bleeder	Neg.	Neg.	
4.	39	W	F	Fever, undetermined origin	Neg.	Pos.	10–15° by tube
5.	72	W	M	Gastric ulcer	Neg.	Neg.	
6.	67	W	M	Cancer of larynx	Neg.	Neg.	
7.	53	W	M	Possible pernicious anemia	Neg.	Neg.	
8.	72	W	M	Cancer of tongue	Neg.	Neg.	
9.	28	W	M	Possible duodenal ulcer	Pos.	Pos.	
10.	52	C	F	Gastritis, possible gastric ulcer	Pos.	Trace	
11.	54	W	F	Pernicious anemia	Neg.	Neg.	
12.	70	W	M	Cancer of tongue	Neg.	Neg.	
13.	44	C	F	Ameloblastoma	Trace	Trace	
14.	54	W	F	Rheumatic and coronary heart disease cirrhosis	Neg.	Neg.	

TABLE 2

Tubeless Study

CASE NO.	AGE	RACE	SEX	DIAGNOSIS	RESULT
1.	25	W	M	Normal	Pos.
2.	25	W	M	Normal	Pos.
3.	26	W	M	Normal	Pos.
4.	26	W	M	Normal	Pos.
5.	33	W	M	Normal	Pos.
6.	26	W	M	Normal	Pos.
7.	26	W	M	Normal	Pos.
8.	48	W	F	Possible cancer of stomach	Pos.
9.	75	W	F	G.I. bleeder	Neg.
10.	45	W	M	Decubitus, left hip, paraplegic	Trace
11.	43	W	F	Cancer of uterus	Pos.
12.	61	W	F	Postsympathectomy peripheral vascular disease	Pos.
13.	39	W	F	Fever, undetermined origin	Pos.
14.	53	C	F	Polyradiculoneuritis	Pos.
15.	44	C	F	Lymphadenopathy	Neg.
16.	61	W	F	Paraplegia	Trace
17.	63	W	M	Postoperative cancer of tongue	Neg.
18.	59	C	M	Postoperative cancer of larynx	Pos.
19.	45	W	M	Paraplegia	Trace
20.	32	W	M	Paraplegia	Trace
21.	15	W	M	Paraplegia	Trace
22.	29	W	M	Paraplegia	Trace
23.	41	W	M	Mitral valvular disease	Pos.
24.	72	W	M	Gastric ulcer	Neg.
25.	24	W	F	Paraplegia	Pos.
26.	44	W	M	Legg-Perthe's disease	Pos.
27.	48	W	F	Essential hypertension; chronic pancreatitis	Pos.
28.	75	W	M	Bladder tumor, papilloma	Neg.
29.	67	W	M	Cancer of larynx	Neg.
30.	53	W	M	Possible pernicious anemia	Neg.
31.	72	C	F	Cancer of tongue	Neg.
32.	28	W	M	Possible peptic ulcer	Pos.
33.	52	C	F	Gastritis, possible gastric ulcer	Trace
34.	41	W	F	Post-cholecystectomy	Neg.
35.	38	W	M	Indirect inguinal hernia	Trace
36.	40	W	M	Ruptured intervertebral disc	Trace
37.	54	W	F	Rheumatic and coronary heart disease, cirrhosis	Neg.
38.	74	W	F	Coronary heart disease	Trace
39.	46	W	F	Thrombophlebitis	Neg.
40.	62	C	M	Nodular goiter	Pos.
41.	53	C	M	Chronic emphysema	Neg.
42.	46	C	F	Postoperative cancer of breast	Neg.
43.	38	C	M	Paraplegia	Pos.
44.	54	W	F	Pernicious anemia	Neg.
45.	70	W	M	Cancer of tongue	Neg.
46.	44	C	F	Ameloblastoma	Trace
47.	39	W	M	Paraplegia	Neg.
48.	70	W	F	Hypertensive heart disease	Trace
49.	63	W	M	Rheumatoid disease	Neg.
50.	45	W	F	Osteoarthritis	Neg.

6 of these were cancer patients. Another 6 negatives had chronic debilitating diseases, 1 pernicious anemia,[6] 1 possible pernicious anemia, and 1 a gastric ulcer. Of the 12 trace readings, 6 were in paraplegics, and 2 had hypertensive cardiovascular disease.

In vitro enzyme study (table 3). In the cases of gastric pepsin, saliva, and salivary diastase, controls were turbid, making it impossible to tell without ultraviolet spectrophotometry whether or not quinine was eluted from the resin. In the cases of ox bile, pancreatin, pancreatic amylase, and dilute lactic and hydrochloric acids there was turbidity in both the raw and treated filtrates, indicating that in saturated solutions of these materials quinine is separated from the Granules.

TABLE 3

*Enzyme Study**

MATERIAL	TREATED (quinine extracted)	UNTREATED	
		Direct	Control (no Diagnex)
Gastric pepsin	Pos.	T	T
Powdered bile extract	Pos.	T	NT
Pancreatin	Pos.	T	NT
Pancreatic amylase	Pos.	T	NT
Dilute lactic acid	Pos.	T	NT
Dilute HCl	Pos.	T	NT
Salivary diastase (*Aspergillus oryzane*)	Pos.	T	T
Human saliva	Pos.	T	T
Urease	Neg.	T	NT
Water (control)	Neg.	NT	NT

* Key: T indicates turbidity, NT no turbidity

DISCUSSION

Clinical study. It appears on the basis of several reports that a new, practical, and for the patient more comfortable method of gastric analysis has been found.[7-11] Eighty-six per cent of the controls in this series showed positive correlation between tube and tubeless methods. Although these results are significant, larger control groups are necessary to study situations like the 1 case in this series in which a positive was obtained by tube and a trace by tubeless. The situation wherein acid is found by tubeless but not by tube may represent greater sensitivity of the tubeless method, since it is known that many factors affect the accuracy of the routine analysis.[12-18]

Enzyme study. Investigation of the activity of certain digestive secretions in the presence of Diagnex indicated that a source of error deserving of further study may be present. It was not possible to evaluate the role of gastric pepsin and saliva by this test because the controls were positive. Under certain laboratory conditions, however, quinine is released from ox bile, pancreatin, pancreatic amylase, and dilute lactic as well as dilute hydrochloric acid, thus raising the question of nonspecificity of this test. It is recognized that this investigation was conducted with saturated solutions in vitro, not with physiologic concentrations in vivo.

CONCLUSION

Especially with respect to pernicious anemia,[19] peptic ulcer,[20-23] and gastric carcinoma, the general practitioner feels the need for a test such as this. Its potential usefulness as a screening method for large groups of patients (e.g., a cancer detection center) is obvious. A technician working at average speed can analyze about 10 samples per hour.

For most purposes it is sufficient to know whether or not there is free acid, without knowing the precise quantity. To make this a quantitative test it would be necessary to set up a series of photometric standards against which unknowns could be read.

Since the early recognition of gastric carcinoma is of ever-increasing importance, a word of caution is in order. A group of 867 patients reviewed by Smith et al[24] were divided into those with malignant or benign gastric ulcers. Histamine stimulation was not used prior to gastric analysis, so that results may be considered to represent functional secretion. In the group with malignant ulcer the percentage of patients with achlorhydria (8.8 per cent) was only 3 per cent less than that of patients with hyperchlorhydria (11.8 per cent), and the largest percentage (57.3 per cent) was in the normal range of acidity. In the group with benign ulcer the largest number of patients was in the normal range, but 5.1 per cent had achlorhydria. These figures shed new light on the problem of achlorhydria as related to gastric malignancy.

SUMMARY

1. Experience with an easy and comfortable tubeless method of gastric analysis is described.

2. Results of this method in 50 subjects (14 as controls) are presented.

3. Effects of digestive secretions on the test substance are described. These early tests suggest that the tubeless method may indicate the presence of other substances than gastric HCl, namely, bile, pancreatin, pancreatic amylase, and dilute lactic acid.

4. Clinical applications and suggestions for further study are briefly outlined.

Acknowledgment is made to Dr. Jeanne C. Bateman for her encouragement and guidance; to the House Staff, Nursing Staff, and Laboratory personnel at the George Washington University Hospital for their kind indulgence; and to Mr. Frank Delaney for photography.

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SYNCHRONOUS CARCINOMA OF RECTUM AND ESOPHAGUS

Report of a Case

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MULTIPLE primary malignant tumors are not rare. The literature was extensively reviewed through 1944 by Warren and Gates,[1] Slaughter,[2] and Warren and Ehrenreich.[3] In the 2 autopsy series of carcinoma cases analyzed by Warren and Gates[1] and Warren and Ehrenreich,[3] an average incidence of 6 per cent was given. If surgical cases were included, the incidence should be higher.

Multiple primary malignant tumors may be synchronous or metachronous, synchronous when cancers occur at the same time, and metachronous at different times. They occur most commonly in the same organ, e.g., the skin, or in the organs of the same system, e.g., the gastrointestinal tract.

Cases of multiple primary malignant tumors occur more frequently than can be explained on the basis of chance alone. A malignant tumor not only confers no immunity to an individual, but moreover seems to cause increased susceptibility or predisposition to another. Warren and Ehrenreich[3] calculated a frequency of multiple malignancies to be 11-fold in their series of autopsies. The successful removal of one cancer should be followed by thorough periodic examinations to elicit a possible metachronous malignant tumor. An interesting case of multiple primary malignant tumors is reported to emphasize the importance of continuous search for such possible focus or foci.

REPORT OF CASE

A 62-year-old white man was admitted on September 16, 1953 with chief complaints of diarrhea and marked weight loss of 9 months' duration. In 1948 he was told that he had a small inactive spot on one of his lungs. He did not have another X-ray examination of the chest until 3 months before admission when he went to the Chest Clinic for a check-up because of persistent severe diarrhea of more than 10 non-bloody stools daily for the previous 6 months. Weight loss was considerable but the exact amount unknown. His appetite had been poor. An X-ray film of the chest at the Clinic revealed active pulmonary tuberculosis, which led to his admission.

The past history revealed recurrent attacks of arthritis of both knees and hips. The patient had always lived in Washington, D. C.

Review of the systems revealed an inconsistent story of difficulty in swallowing associated with intermittent precordial pain of 6 to 18 months.

Physical examination revealed the patient to be in good general condition but with evidence of recent weight loss. The blood pressure was 120 mm. Hg systolic and 80 mm. diastolic. The only other finding of significance was occasional moist rales in the apex of the right lung.

Repeated stool examinations were reported as containing "*Endamoeba histolytica* cysts and parasites." Blood counts and uranalyses were within normal limits. Sputum examination was positive for acid-fast organisms. An X-ray film of the chest revealed moderately dense and patchy confluent infiltration in both apices and a 2½ cm. cavity behind the right first anterior rib. A gastrointestinal X-ray examination was reported "normal esophagus and upper gastrointestinal tract." An electrocardiogram was within normal limits. The diagnoses were pulmonary tuberculosis, moderately advanced, and amebic dysentery.

Streptomycin and isoniazid were given for tuberculosis. Anti-amebic therapy failed to control the diarrhea, which persisted at a rate of 15 to 20 watery stools daily and began to show streaks of bloody mucus. Further investigation revealed a mass in the rectum. Sigmoidoscopy revealed a fungating tumor at 12 cm. above the anus. Biopsy of the tumor was taken and reported as papillary adenocarcinoma. The barium enema was interpreted to show a large annular filling defect causing complete obstruction to the inflow of barium at the rectosigmoid junction.

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* Now on military leave as Major in the Medical Corps of the Army of the United States.

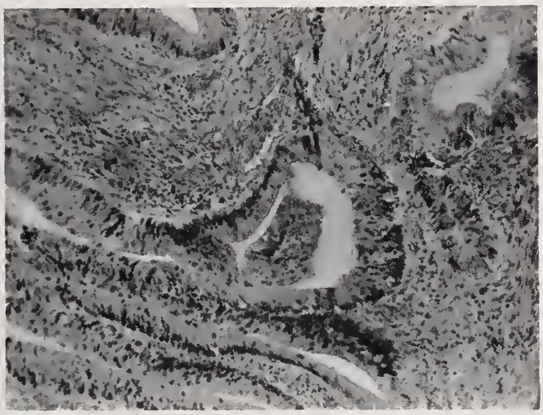

FIG. 1. Papillary adenocarcinoma of the rectosigmoid junction.

The patient was prepared for surgery with colonic irrigation, transfusion of whole blood, low residue diet, and succinylsulfathiazole. On January 6, 1954 laparotomy revealed a large tumor at the rectosigmoid junction. The colon proximal to it was slightly edematous and contained a considerable amount of fecal material. No metastases were present in the liver or regional lymph nodes. A Miles' operation was performed. The patient made an uneventful recovery and had normally formed stools through the colostomy. Subsequent stool examinations failed to demonstrate *Endamoeba histolytica*.

One week after the operation the patient began to experience precordial pain after meals, lasting a few minutes to 2 hours. It increased in severity, became constant, non-radiating, and was located mainly to the left of the sternum and was not relieved by vasodilating drugs. Serial electrocardiograms showed no evidence of myocardial disease or coronary insufficiency. Dysphagia then occurred and gradually increased in severity until the patient voluntarily placed himself on a liquid diet. Examination of the esophagus while the patient swallowed barium disclosed "slight irregularity of the walls of the lower portion of the esophagus, probably due to esophagitis." Esophagoscopy revealed an ulcerative lesion near the cardiac end. Biopsy of the lesion disclosed an epidermoid carcinoma.

On February 17, 1954, an esophagectomy was performed through a left thoraco-abdominal incision with the anastomosis between the esophagus and the stomach just below the arch of aorta. No evidence of metastases was found in the regional lymph nodes and the liver. The stomach appeared normal. The diaphragm was sutured loosely around the stomach to avoid constriction. The patient made an uneventful recovery from the operation.

Two weeks later he started to complain of some difficulty in swallowing and fulness in the chest following meals. Roentgenologic examination with barium showed slight constriction of the stomach at the level of the diaphragm. Esophagoscopy revealed no stenosis at the gastro-esophageal anastomosis, absence of gastric retention, normal gastric mucosa, and slight constriction at the level of the diaphragm. Fluoroscopy revealed a paralyzed left hemidiaphragm. Cortisone was given to improve the general condition, and the patient gained some weight.

The following pathologic reports were submitted by the pathologist, Dr. Charles Aronstein:

1. The rectal specimen contained a cauliflower annular tumor 12 cm. from the anus. It almost completely obstructed the lumen. Several enlarged lymph nodes were present in the mesocolon adjacent to the tumor. Histologic sections showed papillary adenocarcinoma of the rectosigmoid junction (figure 1), no evidence of metastasis in the lymph nodes, and no evidence of amebiasis.

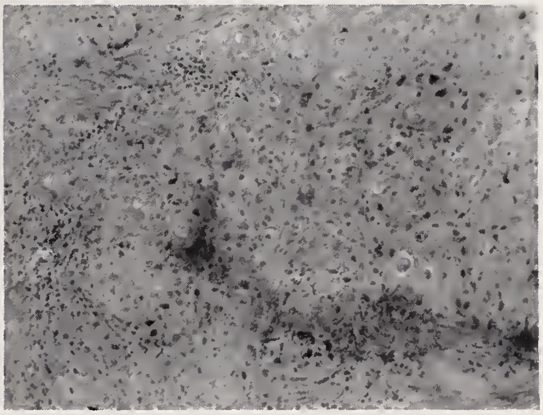

FIG. 2. Epidermoid carcinoma of the esophagus.

2. The esophageal specimen contained the cardiac end of the stomach and 12 cm. of the esophagus. A large ulcerative lesion was present in the esophagus 6 cm. from the cardia. Histologic sections showed an epidermoid carcinoma of the esophagus (figure 2). The specimen contained 1.5 cm. of grossly normal esophagus proximal to the tumor. A section taken from its proximal end was reported to contain "foci of in situ epidermoid carcinoma adjacent to the infiltrating epidermoid carcinoma." The lymph nodes contained no tumor cells.

DISCUSSION

The illustrated case had 2 primary malignant tumors, epidermoid carcinoma of the esophagus and adenocarcinoma of the rectosigmoid junction. They fulfilled all the criteria of multiple primary malignant tumors set up by Warren and Gates[1]; namely, (1) each tumor presented a definite picture of malignancy, (2) each tumor was distinct, and (3) the probability of one tumor being a metastasis of the other was excluded.

The duration of symptoms caused by either carcinoma was about the same. If both tumors were diagnosed at the same time, abdominoperineal resection should still be performed first because of partial obstruction of the carcinoma at the rectosigmoid junction and intractable diarrhea, which caused considerable debilitation and derangement of the electrolytes. The absence of *Endamoeba histolytica* and diarrhea following the Miles' operation indicated that the diarrhea was caused by the carcinoma at the rectosigmoid junction and hyperperistalsis due to partial obstruction of the new growth.

The symptoms of the carcinoma of the esophagus were thought to be cardiac in origin at first. Esophagoscopy revealed the true cause. The postoperative symptoms could be caused by diaphragmatic pull if the left hemidiaphragm were not paralyzed.[4] A stricture of the stomach at the level of diaphragm following esophagogastric anastomosis will cause retention of food proximal to it. Since neither is true in this case, the symptoms are thought to be due to bilateral vagal resection.

The term "carcinoma in situ" was first used by Broders[5] in 1932 to designate those lesions in which the cells are histologically malignant but have not yet invaded the basement membrane of the epithelial layer. Other authors have reported such lesions in many organs of the body. Ewing[6] has accepted them as being examples of multicentric origin of cancer. In this case these foci were found microscopically in the grossly normal proximal margin of the resected esophageal specimen.

SUMMARY

A case of synchronous adenocarcinoma of the rectosigmoid junction and epidermoid carcinoma of the esophagus was reported to emphasize the importance of periodic examinations to elicit possible multiple primary malignant tumors.

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EPHRAIM McDOWELL, PIONEER SOUTHERN SURGEON

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ON THE thirteenth of December, 1809 Dr. Ephraim McDowell received a call to come at once to see a Mrs. Jane Crawford, living in Green County, Kentucky, some 16 miles distant from Danville. After a hard journey on horseback Dr. McDowell reached the Crawford household. There he found two local doctors in puzzled consultation. Mrs. Crawford presented a most unusual and puzzling condition. She was thought to have gone beyond her time in childbirth.

Upon examination Dr. McDowell found her to be suffering from pains very similar to those of labor. The two other doctors present, schooled in the uncertain science of the new country, thought that this was a very difficult case of childbirth which required more expert assistance than they were able to offer. But a rapid and thorough examination convinced Dr. McDowell that the womb was empty. Mrs. Crawford was not with child. She was suffering from an enormous growth arising from one of her ovaries.

Ovarian tumors in those days were puzzling; very little was known about them. Doctors were not very expert in diagnosing them. This lack of knowledge was often productive of tragic results. Dr. McDowell recalled the case of the young daughter of a minister. She was unmarried and had become the victim of one of these tumors. As time went on the tumor grew as a living child within the womb. To all outward appearances this girl was pregnant.

Wagging tongues fabricated malicious lies that spread like wildfire through the sparsely settled community. Scornful fingers pointed meaningfully at her swollen abdomen.

"The minister's daughter is carrying a bastard."

"She has the gall to say she is not with child."

"A fine one she is."

"She refuses to tell who the father is."

"She has brought shame on her good father's name."

"You can never tell about these quiet ones."

A confusion of evil, pointed tongues, thin, pinched faces, and acidulous stomachs. Talk, talk, talk. She knew that she was the victim of some strange internal growth, but she could not convince them because they refused to be convinced. Louise finally took her life in desperation. The doctors opened her abdomen and now they knew that she had been telling the truth; she had never been pregnant. Growing from one of her ovaries was a tumor which gave all the outward appearances of a growing child. Louise's reputation was saved, but Louise was dead.

These thoughts raced through the mind of Dr. McDowell as he concluded his examination of Mrs. Crawford. At length he told her that she was not pregnant, but instead that there was a tumor growing from her left ovary.

"There is no medicine I can give you which will cause this tumor to recede even a little. From what I know of ovarian tumors this one will certainly continue to grow larger with perhaps a fatal outcome. There is nothing in all the materia medica which can be of any help to you. The only relief you can hope for is from an operation which will remove the tumor."

Ephraim McDowell was lost in deep thought for a few minutes. Then he continued: "But it is only right for me to tell you that I have never before removed such a tumor. Nor do I know of any doctor who has. If you are willing, and with the help of God, I shall undertake this operation."

CAT

Mrs. Crawford was made of the stuff of pioneers. She was courageous, as were the majority of the women of the wild Kentucky country of that period. Her eyes had seen much blood; her body had known a great deal of pain. She was hardy and durable. She had known life in its crudest and sternest aspects. There was not even a tremor on her lips when she replied: "Doctor, I am ready for the operation."

So to Danville traveled Mrs. Jane Crawford, on horseback. A special saddle was constructed to hold the enormous growth. The journey was one to try the mettle of the hardiest of bodies. It was accomplished without incident.

Dr. McDowell sent for his nephew, Dr. James McDowell, to assist him in his greatest adventure. Mrs. Crawford was placed on a table of half logs, flat side uppermost. There was no donning of white germ-free gowns, no sterilization of rubber gloves and gleaming steel instruments. Ether and chloroform were unknown in 1809.

McDowell was ready for the greatest bit of pioneering that the pioneering McDowells had ever undertaken. He was to perform an operation that no man had ever dared to think of before. He was to take the first step in laying open the mysteries of the human abdomen, in exposing the insides of the body to the healing steel of the surgeon's knife. He was to make Dr. Bell's dream come true at last; Dr. Bell, his old teacher at Edinburgh, had dreamed of the day when surgeons would become bold enough to perform abdominal operations.

Ephraim McDowell felt that this was the most solemn moment in his life; he knelt down and prayed:

"Almighty God, be with me, I humbly beseech thee, and in attendance in this holy hour; give me awe in Thy presence, grant me Thy direction and aid, I beseech Thee, that in confessing I may be humble and truly penitent in prayer, serious and devout in praise, grateful and sincere, and in Thy word attentive and willing and desirous to be instructed. Direct me, O God, in performing this operation, for I am but an instrument in Thy hands, and am Thy servant, and if it be Thy will, Oh! Spare this poor, afflicted woman. Oh! Give me true faith in the atonement of Thy Son Jesus Christ, or a love sufficient to procure Thy favor and blessing, that worshiping Thee in spirit and in truth my services be accepted through all sufficient merit. Amen!"

Dr. McDowell removed his coat and signaled for the strong men who had come to assist him in holding down the arms and legs of Mrs. Crawford. The knife bit into the abdomen and swept straight and sure for a distance of 9 inches. As soon as the incision had been completed the intestines rushed through the open wound and upon the table, so great was the pressure the tumor exerted.

The beginning of the adventure was indeed a gloomy one. He made an attempt to replace the protruding intestines but without success. The news of this fearsome accident drifted outside the cabin where a good-sized crowd of rough, bearded Kentucky men had gathered. There was a droning buzz of angry excitement.

"It looks bad for Jane Crawford. She should never have allowed him to use the knife on her."

"Is he God Himself that he thinks that he can cut a body's belly open and meddle with the innards?"

"He's no doctor, but a butcher who loves the smell of blood."

"Get a rope ready. His neck will find a noose as soon as Jane Crawford dies."

"The rope is ready. Now let butcher McDowell take heed."

The steadily increasing drone of angry muttering outside the cabin door reached McDowell's ears as he worked deftly amid gushing blood vessels in a gory and unfamiliar field. The tumor was removed, all 15 pounds of it. The intestines were then readily replaced. The wound was sewn together and further reinforced with strips of adhesive tape. Then clean dressings were applied and Mrs. Crawford was lifted from the rough table and put to bed. The operation took 25 minutes.

Mrs. Crawford had not died on the operating table. She lived through that awful bout of nerve-tearing pain. The rope was never used. Dr. McDowell saw the mob disperse. The operation had been performed with success. But would Mrs. Crawford live for any length of time?

Five days later he visited her again, and much to his astonishment and gratification he found her engaged in making her bed. Mrs. Crawford, though pale and weary, was free from pain and able to perform her household duties. Jane Crawford was indeed made of sturdy, durable stuff. She recovered completely within a month and lived to the age of 80, which would certainly not have been possible had the tumor been allowed to grow within her. She was grateful for the relief the operation had brought her, even though she had lived through a nightmare of pain in its performance.

All the McDowells were pioneers. They laughed in the teeth of death as they pushed into new fields beyond the golden sun. Blood and steel, war and muskets, many masted ships that tossed fitfully on boiling seas, red men and tomahawks, the cold, cheerless winters of a home in the wilderness, these the McDowells had known.

Fiercest of all the clans besides the Campbells, fighting against the tightening oppression of the Stuarts, disease-maddened rulers of England, were the stalwart sons of Dowell; borne of brave Dougal, the worthy son of the immortal Somerland, they had from time immemorial marched and fought under the clodberry bush, which in time became the symbol of their clan. They marshalled under the banner of the ancient Lords of Lorn, the hereditary chiefs of their race, and fought with uncommon valor for their beloved Scotland.

When the new lands beyond the sea known as America were being colonized, a brave band of McDowells emigrated to the colony of Pennsylvania, where they settled in 1729. Ephraim McDowell, a warrior of Boyne River and Londonderry, was already an elderly man when, with his two sons, John and James, his daughters, Mary and Margaret, and a goodly number of kinsmen, he came to settle in the new, wild country.

The McDowells remained in Pennsylvania but a few years. Here John married Magdelena Wood, whose mother was a Campbell, of the clan which fought side by side with the Dowells in the old, brave days. The Campbells had also come to America, to seek new fortunes. In Pennsylvania was born Samuel, who was to become the father of Dr. Ephraim McDowell, the greatest McDowell of them all.

Samuel McDowell moved south, where he settled in Rockbridge County, Virginia. Here Ephraim was born on November 11, 1771. For 13 years the McDowells lived in Virginia, but the urge to explore new territory again entered the McDowell blood. They pulled up stakes and moved to Danville, Kentucky, where they settled. Danville was one of the outposts of the Boone Trace where life was harder and certainly more unsettled than in the elite northern colonies. But the McDowells seemed to thrive on hard life.

Ephraim spent the early years in a cabin built of felled logs. The floor was of rough logs, split into planks. The roof was of bare slabs laid like shingles, held in place by a log for weight. The windows were made of paper rubbed with hog's lard to make them translucent. In the summer the clay clinging between the logs was removed to permit ventilation of a sort. In winter they were filled in again to keep out the bitter cold.

Educational opportunities in the new country were as meager as the food and clothing. Young McDowell received a smattering of classical learning in the seminary of Messrs. Worley and James. Doctors were scarce in Kentucky and Ephraim determined to become one. There were no medical schools anywhere in the Boone Trace. The usual thing was to enter a doctor's office, to read his books and examine patients with him. Young Ephraim went to Staunton, Virginia, where he entered the office of Dr.

Humphrey, with whom he remained for three years.

Dr. Humphrey was a graduate of the University of Edinburgh, and this was responsible for Ephraim McDowell's overseas journey to Scotland to round out his medical education. The years 1793 and 1794 were spent in Edinburgh, and it was here that he came in contact with John Bell, who lectured on the diseases of women. Dr. Bell was much disturbed about ovarian tumors, which started as small growths from the ovaries and eventually attained gigantic proportions. The inevitable outcome was death. No one ever thought of attempting to remove such a growth. Dr. Bell himself shuddered at the thought. But he did venture to predict that some day it would be possible to remove ovarian tumors and save the woman's life.

In 1795 Dr. McDowell returned to Danville and began practice. He was both physician and surgeon to the hardy pioneers who had settled in the vicinity of Danville. He might have practiced his profession for the remainder of his life as a backwoods doctor like countless others, and like these others might have been forgotten. But fate and the pioneering McDowell spirit decreed otherwise. Fate had thrust the same opportunity countless times into the laps of others, but the old McDowell desire to venture into the unknown was the factor which decided Ephraim McDowell to make the most of this opportunity.

The fame of Ephraim McDowell grew after the Crawford operation, but his reputation suffered some weird twists. Like most pioneers in unfamiliar fields he had to contend not only with the prejudice and envy of his own colleagues but also with the superstitious awe of the rough and ignorant woodsfolk who were his neighbors.

Among the Negroes Dr. McDowell had attained, because of his operation, an ungodly renown. One afternoon as he was making his way home he met a Negro of gigantic proportions in a solitary part of the road face to face. The Negro looked at Dr. McDowell for a fleeting moment of terror and took to his heels. The doctor ordered him to halt. The Negro obeyed, with fear contorting his every feature. With eyes staring wildly, almost out of their sockets, he fell on his knees and began to pray. Dr. McDowell waited until he was through.

"Why did you run away when you saw me?" he asked the quaking Negro.

"Pray have mercy, doctor. Folks say that you go about cutting people open and killing them." Dr. McDowell tried to convince the Negro that this rumor was entirely groundless, but he met with little success. His reputation remained fearsome to the backwoods folk for a great many years.

The fame of Dr. McDowell as a surgeon had by now thoroughly permeated the surrounding countryside. In 1813 he was called upon to see his second case of ovarian tumor. This was in a Negro slave. In spite of his previous success, Dr. McDowell did not operate at once. He was always the true healer. He tried all nonsurgical measures before he finally resorted to surgery. Patiently he treated the Negress with mercury for a period of 4 months. There was only a slight abatement of the pain. The tumor was not affected in the slightest. It grew more massive and incapacitated its victim entirely.

Negro women are particularly fertile soil for these rapidly growing and debilitating tumors. Quite often more than one tumor is found to complicate matters. Dr. McDowell thought that to operate on this patient was inadvisable. But the master of this Negro slave had the greatest confidence in Ephraim McDowell's surgical skill. He implored him to operate.

The operation on this second case of ovarian tumor was more difficult than the first operation on Mrs. Crawford. There was a great loss of blood and the tumor was extracted with the greatest difficulty. The planks of the table were stained red with blood. At the completion of the operation Dr. McDowell had a feeling that all had been in vain. He attended her anxiously for several weeks. She recovered in a few months and was able to resume her hard life in the fields.

The pioneering of Dr. McDowell was bearing fruit. Both his ventures had been eminently successful. He was now respected as a surgeon of incomparable skill in removing these growths. His third call came in the summer of 1822. He made a horseback journey of several hundred miles into the middle of Tennessee to remove an ovarian tumor from Mrs. Overton, who lived near The Hermitage, the residence of General Andrew Jackson.

Mrs. Overton was enormously obese, and Dr. McDowell had to cut through many layers of fat before reaching the tumor. It was a very messy affair. There were no trained nurses in those days, and the neighbors were pressed into service. On this occasion Dr. McDowell had as his assistants a Mrs. Priestly and General Andrew Jackson, who held the struggling, elephantine Mrs. Overton as best they could. This was perhaps the only time in history that a future President of the United States acted as an assistant at a surgical operation.

General Jackson was a pioneer, and as a pioneer he appreciated the pioneering of Ephraim McDowell. He was certainly most vividly impressed with McDowell's skill as a surgeon. After the operation had been concluded he invited him to remove a large tumor growing from the neck and shoulders of one of his men. Dr. McDowell removed the growth with a few deft strokes of the scalpel and with remarkably little pain to the patient. He had learned how to work rapidly so as to spare as much pain as possible.

The news of Dr. McDowell's new operation for removing ovarian tumors traveled slowly to the outside world in those days when newspapers were scarce and medical journals still scarcer. In 1817 Dr. McDowell published the results of his operations in a Philadelphia medical journal. It took two years for his work to be recognized outside America. The first recognition came from Germany, where in 1819 Dr. Chrysmar performed the operation with great success.

In America the McDowell operation was performed in 1821 by Dr. Nathan Smith in New Haven with favorable results. After recognition by this medical leader, the founder of the American Medical Association and other medical institutions in the United States, others began to view McDowell's pioneer efforts with great interest. In New York Dr. David L. Rogers, one of the metropolis's leading surgeons, also gave his approval.

The American surgeons who preached the gospel of McDowell's operation more eloquently than all the others were the brothers Altee, John and Washington. They performed the original McDowell operation and made it popular among surgeons. These were the brave trail blazers in abdominal surgery, the men who made the first advances in the most important branch of the surgical art.

The operation of the Kentucky surgeon now began to attract attention around the world. It was tried and found to be of great merit. In England, Dr. John Lizare, leading surgeon of Edinburgh, performed the operation with life-saving results; in Manchester, Dr. Charles Clay; in London, Dr. Frederick Bird; in France, in Italy and in other countries, the dark mysteries of the human abdomen were explored and the killing disease exposed to light and conquered.

Ephraim McDowell, in spite of world-wide acclaim, remained the simple backwoods surgeon all his life. His operations were performed, not in hospitals but in the lone cabins of his patients. His assistants were not white-gowned interns and nurses, but the rough, simple folk of the Boone country.

Ephraim McDowell died on the twentieth day of June, 1830, while still in his prime. After death the homage paid to this simple backwoods doctor was even greater than during his lifetime. In 1879 a marble monument was erected in his memory in his native city of Danville. But the McDowell operation, which freed women from the maiming grip of ovarian tumors, is the

(*Continued on page 664*)

President's Page

REHABILITATION

A rare opportunity is offered the District of Columbia to provide an outstanding Rehabilitation and Vocational Service to its handicapped people. Functioning as an independent unit, responsible directly to the Commissioners, the Service will be close to the people it serves.

Rehabilitation involves diagnosis and correction of handicapping problems, be they physical or mental. This must be followed by vocational or occupational education and job-finding. No one of these areas can function independently. The physician has an important role in that he is responsible for diagnosis, operative procedures or psychiatric treatment, prognosis, direction of occupational care, prosthetics, and recommendations as to the kind of job the patient is able to handle.

There are five excellent Physical Medicine (Rehabilitation) centers functioning in the District hospitals: D. C. General Hospital, Georgetown University Medical Center, George Washington University Hospital, Freedmen's Hospital, and Children's Hospital. They should all be used to the extent of their facilities.

Businesses and industries must lend a hand for any rehabilitation program to succeed. Government agencies have many positions which can be efficiently filled by the handicapped, and it is just as important that private industry explore all possibilities for utilizing the services of the handicapped.

Coöperative efforts by all concerned are essential to the success of a program which involves multiple disciplines.

Preston A. McLendon

Editorials

DANGER IN THE COMMUNITY

Much of my private practice has to do with "home care" of tuberculosis patients. There are those who will think I am hypocritical when I say I am opposed to "home care" for tuberculosis. But when "home care" rather than hospital care is a practiced principle which affects the community as a whole, I think it is dangerous.

"Home care" is a term loosely used. The ideal situation would involve, first, the careful attention given to a patient by an understanding family. It would mean isolation such as only a private room and a private bath could afford. It would mean careful supervision of the patient's treatment by a physician, and education of both the patient and members of his family about the disease.

I can speak with a fair amount of experience in this respect. It is my belief that such "home care" cannot be furnished by families with much less than a ten-thousand-dollar-a-year income. Today, home care for the general public means inadequate treatment of an active case out of the hospital.

Tuberculosis strikes most frequently among families in the lower-income brackets; in congested areas where families live in close quarters, where any isolation or supervision of a tuberculosis patient is practically impossible; where people are either too busy or too apathetic to learn about tuberculosis. There are not enough doctors and not enough Public Health nurses to take care of all these patients. Treatment of tuberculosis involves a lot more than a clinic visit, the administration of a new drug, or the filling of a prescription.

There is a revealing report on an outpatient program at Freedmen's Hospital in which some 80 people with tuberculosis are involved. The report shows that more than 40 per cent do not coöperate in following treatment instructions. They neglect to fill prescriptions, forget to take their medicine, and prefer TV programs and neighborhood gatherings to bed rest. Freedmen's outpatients are showing poor progress. That is due to a human frailty of which all members of the medical profession are well aware—and one, may I add, to which members of the medical profession also succumb.

I am going to lay my cards on the table. During the first 6 months of this year 857 new cases of tuberculosis were reported in the District. According to the D. C. Department of Public Health, there are 8,132 tuberculosis cases known in the city, of which 2,722 are active. Only 1,230 of the active cases are hospitalized; 1,500 walk the streets. Yet, today, there are 128 vacant beds in District of Columbia tuberculosis hospitals—85 at Glenn Dale Hospital, 7 at D. C. General Hospital, and 36 at Freedmen's Hospital.* The answer is obvious. These beds are empty because known tuberculosis patients are not being referred to hospitals for treatment. There seems to have developed a new philosophy regarding the treatment of tuberculosis in Washington. May I emphasize: I think the way the so-called "home care" program is being managed by the official health agency of the District of Columbia is dangerous.

We all know that tuberculosis is the number one infectious disease in the country. It is true the death rate has dropped dramatically; how-

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* This statement was true on September 29, 1954. Due to an apparent change in Health Department policy, it is gratifying to report that these beds have since been filled.

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia

ever, we are more concerned with the living. How are we going to control the 1,700 new cases discovered in the District every year? My answer would be to follow the accepted concepts practiced for the last half century. Find the case early. Isolate the case promptly. Treat the case adequately.

I agree with the program of a group which for 52 years has been fighting tuberculosis in this city. When the District of Columbia Tuberculosis Association was first organized, the "white plague" was the number one killer. Today, tuberculosis is eighth on the list of fatal diseases. Yet, next to Baltimore, Washington has a higher death rate from tuberculosis than any city in the country. During the year, the D. C. Tuberculosis Association with its Christmas Seal Sale funds has coöperated with the D. C. Department of Public Health in operating an X-ray unit which has offered free chest X-rays to citizens of Washington. The goal was 50,000 X-rays. Already some 75,000 X-rays have been taken. This is a fine project. But of equal importance, I believe, is the work the Association is carrying on through its program of educating the public about tuberculosis. Find the case through a chest X-ray. Isolate the case in a hospital, if possible.

As I have stated, I am a private practitioner. I make my bread and butter treating tuberculosis cases in the home. Yet in the field of tuberculosis in Washington I have spent many hours with the general public. I have known the problems of the indigent case. I have realized the necessity of isolation.

My preceding remarks have expressed my thoughts on the dangers of a general "home care" program. I'd like to go a step farther and say that even though our official health agency talks of its "home care" activities, there is no such program. There couldn't be, if but for one reason alone, an inadequate health department staff to follow through on the work such a program involves.

There should be less talk about "home care." The empty beds in our tuberculosis hospitals should be filled.

James J. Feffer, M.D.
Member, Board of Directors,
District of Columbia Tuberculosis Association

PREOPERATIVE PREPARATION FOR THE SURGICAL PATIENT

Preparation for surgery generally implies the use of various medications and treatments that are in vogue. They have changed greatly in the past two decades. Many years have not passed since the patient was considered a "case," and preparation concerned itself largely with the routine physical preparation, rather than the temporal. Either the introduction of new drugs or the recognition of psychology in its relation to surgery, or both, has brought a wholesome change in our conception and practice in the preparation for surgical operations. The modern approach to preparation could be called the psychologic preparation, with the accentuation or emphasis on the patient-surgeon relation.

The preoperative preparation should begin when a patient is informed that surgery is necessary. Some accept such a decision with complacency, others with reluctance, few with enthusiasm, and most with some degree of apprehension, if not actual dread.

It is at this stage that an understanding physician can do much to remove the doubt and fear of one so possessed and pave the way for the induction into a series of experiences that will be shorn of their disturbing thought.

The doctor may be asked if the operation will be dangerous, if it will be painful, the duration of the convalescence, and if a cure will follow. These queries can be anticipated and answered before they are propounded. The patient is entitled to much of the information requested, but there are occasions, and only too many, when much tact is needed.

The surgeon can and should assure the patient that the modern hospital is not a penal institution or a house of detention, that there is an atmosphere of cheerfulness and kindness about it, and the staff of doctors and nurses are just as human as members of his own family, that it is the aim of everyone to assist in his recovery. He should be told, if it happens to be so, that the prospects of a cure are good, that the operation may be followed by pain for a few days, but sedatives would be used to give relief and restful nights. He should be told of the approximate number of days he will be hospitalized, leaving a margin for complications. Should the fee be discussed? Some patients hesitate to broach the subject, but it is certainly in order and most ethical to ask the patient if he would not like to know of the approximate expense involved. Most patients are relieved to talk of it and never resent the question.

The admission routine in many hospitals could be improved. The first impression when the patient enters the hospital is an indelible one, and whether good or bad, may dominate his behavior during his entire stay. The patient should be given explicit instructions when to enter, be told of the necessary financial arrangements, informed what apparel and toilet articles he may need, the visiting hours, and instructed to whom he should apply for admission. Patients have been known to sit in waiting rooms for hours, expecting someone to seek them out. All details of his admission to the hospital should be checked with the hospital in advance to assure his proper reception and prompt admission. It is most demoralizing to a prospective surgical patient to be kept waiting an intolerable time, to learn that the room is not ready and that special nurses have not been engaged, and worst of all, that a cash deposit was necessary. It is doubtful if many of us can place ourselves in the position of a surgical patient applying to admission to a hospital unless we have had that experience.

If the surgeon visits the patient in the hospital the evening of his admission, it lifts his morale and often insures a quiet night, and this little human touch is greatly appreciated. One last detail of the psychologic preparation is a visit prior to the administration of the anesthetic. The patient often does not recall this attention, but he usually goes to sleep calm and relaxed.

The preoperative preparation is not the responsibility of the surgeon alone, but there should be teamwork by the office secretary and nurse, the hospital information office, the admitting officer, the nurses, and the anesthesiologist. Collectively, they can do much to eliminate the fears, real or imaginary, which dominate the cerebrations of the surgical patient, and the effort will be repaid many times by the end-result.

C. S. W.

THE "NEW LOOK" IN MORBIDITY AMONG CHILDREN

Fifty years ago one needed no complicated statistics to decide what disease was probably the most common killer of the child population; it was only necessary to state the current epidemic to be reasonably correct. Now, in an era of immunization procedures and antibiotics, with the death rates from infectious diseases shrinking each year, the big killer lurks in every home and on every street corner—ACCIDENTS, the leading cause of death among children between 1 and 14 years of age. The morbidity figures are not available for the entire country, but would probably show that an astonishingly large number of children are seen each day by physicians for treatment related to ingestion of toxic substances and miscellaneous home accidents.

With this situation in mind, the American

Academy of Pediatrics is conducting a campaign for the control of accidental poisoning in children as a beginning step in the entire problem of accident prevention. The D. C. Chapter of the AAP is coöperating in the national program by establishing a center for the control of accidental poisoning, where technical information on the identification of toxic ingredients of "trade-name" household substances will be available, and information on methods of treatment of poisonings can be obtained. The center will also collect and compile reports on accidental poisoning with the coöperation of the emergency rooms of 18 hospitals in the Washington Metropolitan Area; these reports will be used to determine the magnitude of the local problem, and will provide comparative figures for a Nationwide study. The project received the endorsement of the Executive Board of the District Medical Society at its September meeting.

The preliminary work of the Washington Metropolitan Area Poison Control Center began July 15, 1954, with headquarters at the Children's Hospital. In the 3-month-period since then approximately 80 reports on poisonings have been received and a number of requests for information have been handled.

Any physician or hospital may obtain technical data by telephoning the Poison Control Center, Dupont 7-4220, Extension 250 at any hour of the day or night.

Every physician can and is urged to become an important part of this program by making his office a source of information to parents concerning the hazards of accidental poisoning in the home.

Allan B. Coleman, M.D.

In and Out of Focus

BY THE OBSERVER

Doctors Are Not Standing Still

In addressing the fall convocation at Georgetown University, marking the beginning of the school's academic year, Dr. Mario Mollari, Professor of Bacteriology and Immunology at the University's School of Medicine, spoke as follows:

> "The public today is aware of the newer trends in medicine, and of its enormous cost to the individual and the family. The demand is growing with greater insistence for more 'good health'. . . .
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> "The public at large is demanding ever more loudly and persistently that 'good health' be given to all, high and low, in the form of diagnosis, treatment, preventive medicine, and public health programs. It has become a social, a moral, and a political factor. The sooner we acknowledge this social phenomenon—this demand by the public for reforms leading to 'good health'—the better off we will be.
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> "If we are not producing the goods, let us come up with some deep thinking and some plans, or somebody else more inclined to politics than thinking may come up with a master plan which will be shoved down our throats. Time does not stand still, and the status quo of the old doctor must give way to newer concepts, just as the horse and buggy had to give way to the automobile and the airplane."

There is no denying that costs of illness are a major problem, and that a satisfactory solution remains to be found. The District Medical Society has long recognized this fact and has been well aware that, as Dr. Mollari says, it has become a "social, moral and political factor."

Dr. Mollari qualified his warning to doctors that they must do some deep thinking and offer some plans by the phrase, "if we are not producing the goods." Nevertheless, there would be no point to his warning if he had not felt that it was necessary. Undoubtedly too many doctors are still doing horse-and-buggy thinking when it comes to the economics of medical care, but there are also many, among them leaders of stature, who are insisting upon and supporting forward-looking plans. They and their medical organizations are making contributions of considerable significance.

It is not necessary to go far afield for an example of this, for it is to be found on our own doorstep. The record will show that, under forward-looking leadership and following months of study, a medical prepayment plan was inaugurated in Washington in 1939. It was sponsored by our Society and was known as Mutual Health Service. Unfortunately, MHS failed after some six months of intensive effort and the expenditure of a considerable amount of funds. In retrospect it is apparent there were many contributing factors: the now historic anti-trust suit against the American Medical Association and the District Medical Society then in progress; politics—the New Deal was in its heyday and its leaders did not look favorably upon the project; inadequacies of the plan—these, of course, would have been modified if MHS had been placed in operation; and the inexperience of the Society's representatives.

There was one bright spot in the Society's experience with MHS. Doctors who had been chosen to guide the plan labored most diligently, and without compensation. They gained experience which was to be of considerable value at a later date. No one could complain, either, about the response of the physicians who were asked to participate. They may have had misgivings about the venture but hundreds of them unhesitatingly pledged their wholehearted support.

Least understandable to many physicians at the time, of course, was the public's apathy. As later became apparent, the program was so generous from the eligible subscribers' standpoint that the plan would have been hard put to fulfill its promises. Despite this, if there had been a genuine spark of interest, the story might have been different.

It is not surprising that some years passed, despite the urgings of a few members of the Society that an alternate plan be undertaken immediately, before another attempt was made. It was not until 1946 that the present Blue Shield Plan, Medical Service of the District of Columbia, was placed in operation with the cooperation of Group Hospitalization, Inc., which agreed to administer the plan. Undoubtedly Mutual Health Service would have fared better if the GHI had not refused to coöperate, but times had changed, and, of course, the new plan was far more acceptable to the officials of GHI.

The Service started from scratch, that is, with no subscribers. As most readers know, it flourished amazingly in a comparatively short time. Today nearly 450,000 persons in the Washington Metropolitan Area are protected under its subscribers' contracts. Now no one claims, least of all those who have guided its destinies, that the Service is all it should and will be. Its coverage is still limited largely to surgery and obstetrics in the hospital, plus ancillary services, including X-ray, laboratory procedures, and anesthesia. No one is more aware of the need for broadening its coverage than the Service's Board of Trustees. Several months ago the Board authorized experimentation with a pilot plan to be made available to a limited number of the Service's subscribers in an effort to ascertain the feasibility of including medical services in the hospital.

In the early summer of 1954 the Eisenhower Administration proposed a program of fringe benefits for Government employees. One of these proposals, later embodied in the bill introduced late in the session of the last Congress, included health insurance benefits, the Government to pay part of the premiums. The bill stipulated that there should be open competition among nonprofit voluntary health insurance plans and commercial insurance companies for this "business."

As a result, officials of Medical Service and the Blue Shield Commission, on which the Service is represented, are diligently seeking to develop a program acceptable to the Government employees.

Now, the point in relating all this is that what the public doesn't see, and what few in the medical profession are aware of, are the efforts being made by medical organizations to ameliorate burdensome costs of illness and to develop workable medical care plans. It is one thing to put a plan on paper and another to operate it successfully, as Service officials have learned from long and sometimes sad experience. Problems pile one upon another as a plan progresses. Details that seemed either unimportant or practical on paper are found to be quite the contrary. Unforeseen complications arise, requiring hours of time and unlimited patience to iron out.

From the standpoint of administration the Service has been in very competent hands; however, lay administrators are not qualified to cope with the professional aspects of the plan. Differences over fees, for example, can only be dealt with by a committee of physicians. It is fortunate, then, that there are physicians who have an understanding of the socioeconomic problems involved, are sympathetic to the plan's purpose, and are willing to devote the time required, yes, often their personal funds, to assure its success. Their names are known to their fellows who, while they have little knowledge of their sacrifices, are aware of their unflagging zeal and loyalty. And last but not least has been the unfailing support of the Participating Physicians; they too deserve a great deal of credit for the success of the Service.

So, returning to the remarks of Dr. Mollari, it can be said that physicians, at least many of their outstanding medical leaders, are only too conscious that "time does not stand still." Today, in all parts of this country, doctors are earnestly endeavoring to prove that voluntary health insurance plans will work and can meet adequately the burdensome costs of illness. It is time that the public, and a good many doctors, too, be made aware of this fact; and that if diligence, interest and loyalty will do the job, it will be accomplished.

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Tarnished Halo?

South Carolina physicians are more articulate than most of their colleagues. All that is required to demonstrate the truth of this statement is a challenging issue, unwarranted criticism, or attack upon a cherished tradition. It is then that their unusual gift for the telling phrase and dramatic periods rise to the occasion with stirring eloquence. One suspects that the most talented are preachers' sons, but certainly not all are. More likely it is an integral characteristic of the native South Carolinian.

Usually addresses by incoming presidents of state medical societies are compounded of hackneyed phrases and oft-repeated sentiments. Only by chance, therefore, did your Observer begin reading an address which appeared in the September issue of the *Journal of the South Carolina Medical Association*. It was entitled, "A Doctor Examines His Profession"; the author, Dr. C. R. F. Baker, of Sumter, S. C., President of the Association.

Beginning with the first paragraph it is lively and pungent reading. Here is a doctor who has something to say, minces no words, and commands the picturesque phrase. His thesis: the doctor—yesterday's hero, today's scapegoat.

> "Some few years ago," Dr. Baker says, "the public placed the doctor on a pedestal, and made him a popular hero—the darling of the hour . . .
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> "Contemporary fiction, radio soap-opera, and the movies spent their all in polishing up the doctor's halo. Doctor heroes were sure-fire, and what doctors they were—only a little taller than the angels in skill, nobility of character, and physical endurance that assured their patients twenty-four hour service complete with toothpaste-ad smiles. They, every last one of them, looked like young Doctor Kildare (one novel had the saccharine title

> 'Young Doctor Galahad') and they all had the medical genius of a Dr. Harvey Cushing or the genial warm personality of a Buck Pressly [William L. Pressly, Due West, S. C., AMA's General Practitioner of the Year for 1948]. They never, never lost a patient or even bothered to send a bill. They were above and beyond the common run of men.
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> "So removed in spirit from ordinary humanity, they seemed to have no crass details like grocery bills or insurance premiums or keeping three kids in college at the same time to agonize about. Medicine was praised, honored, even revered. 'The beloved profession,' some woman writer, her pen dipped in treacle, called it. Doctors were classed with ministers and teachers, and spoken of with genuine regret as overworked, self-effacing, and underpaid! But what spiritual dividends a doctor reaped—what other profession offered such a chance for soul-satisfaction—for following the precepts of the beloved physician, St. Luke, and for dedicating one's earthly existence to the saving of lives and the alleviation of human suffering. The public truly believed that doctors spent their lives in the beautiful shadow of the Hippocratic oath, and took them to its heart with an awed and fanatical devotion."

But, continues Dr. Baker, such a "Utopian love affair" could not go on forever.

> "Doctors were not angels, not infallible, not more patient or unselfish than other men. Patients did die, and some doctors did overcharge, and some surgeons did get themselves a little confused with God, and a few did advertise or take to dope or perform illegal abortions, and a few were incompetent, and a few became rich and indifferently callous to the sufferings of the poor; a few were misfits or dishonest, and a few were lazy and took no pride in their work, seeing nothing in it but a means of livelihood. Doctors were even then, as they are now, ordinary human beings, but enlarged in public opinion to king size."

Philosophically, Dr. Baker observes, "fashions in heroes change and the pendulum of admiration for the M.D. swung over to censure of him." Examples of "invective," "hostility," and "open resentment," he says, are a number of critical articles which appear in current popular magazines. They contribute to the impression that doctors instead of their patients drive Cadillacs; that their wives wear wild mink and emerald clips, and that they live in $100,000 mansions dubbed "Gallstone Gardens," "Cardiac Castle," or "Appendectomy Acres."

The most frequent complaints against the medical profession, he states, are that they are responsible for the fact that (1) there are not enough physicians, (2) that the cost of medical care is excessive, and (3) that hospitalization is too expensive.

In rebuttal, Dr. Baker says that in 1922 there was one doctor for every 729 persons in this country, and in 1950 there was one for every 730; that there are better doctors now than there were twenty-five years ago because Grade-B medical schools and diploma mills have been eliminated Enrollment in medical schools has also been increased, 6,080 physicians graduating in 1952 and a still larger number in 1953. The American Medical Association, he observes, has donated one and a half million dollars from its own treasury to support medical schools. Does that sound like the AMA is for limiting the number of doctors, he asks.

Today the "average person pays only 4 per cent of his income for medical care, the same as his parents before him. Of this 4 per cent the doctor gets only 28 per cent, and the rest goes for medicines, hospitalization, etc. Twenty years ago the doctor got 32 per cent, more than at the present time."

As for hospitalization, he admits that the cost has gone up more rapidly than any other expense connected with illness, but he insists that hospitalization has been shortened and "often the hospital bill is lower than in the good old days."

In summing up, he concludes: "In public opinion our halo may have dimmed a little but, human shortcomings notwithstanding, medicine is still a going concern."

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Letter to a Medical Graduate

A modest, able educator, Dr. Joseph H. Roe, Professor of Biochemistry at George Washington University School of Medicine, gives some sage advice in "A Letter to a Medical Graduate" which appears in the

September 1954 issue of *The Journal of Medical Education.*

On financial rewards in medical practice, Dr. Roe writes:

"...Your code says that this objective shall be a subordinate one, but it does not imply that it should be absent. The physician is most certainly entitled to a financial consideration in keeping with his services. To be realistic, he needs to earn a liberal stipend in order to serve best his fellowman. Specifically, he needs money to provide for himself those things that will keep him the most efficient under the heavy strain and responsibility that he must bear. These include a good home, efficient equipment, good assistants, liberal allowances for the complete care and education of his family, travel to professional meetings, relaxation, vacation, and the privilege of saving something for the time when he will have to become less active.

"The medical profession has met this challenge squarely as a group, although some bad individual exceptions do exist. It is the rule of the profession to treat the poorest person with the same care and professional skill as the more fortunate wealthy patient. You have already committed yourself admirably in this respect by the tremendous effort you have put forth thus far at a financial loss. In the financial race, your college classmate who went into business when you started for medical school will enjoy a large financial advantage over you by the time you first have patients in your office; and if he puts forth as much effort as you will use, he will make a financial amateur out of you in the long run. Thus, your financial record is one of self-sacrifice so far. It always will be good if you remain true to the principle of giving adequate time and your best efforts to the service of your patients without thought of financial reward. Of course it is clear to you that the highest satisfaction of the medical profession is in being able to serve humanity; this transcends financial reward."

On keeping up with advances in medicine:

"...The closer you keep to the basic sciences, the better it will be for your professional growth. Your instructors have kept in mind the importance of a training so rigid in basic science that it will carry forward with you for many years the capacity and desire to dig into current medical literature. This is so important because of the advances in the practice of medicine that are sure to come as a result of scientific research—advances that will very probably accelerate in the future. New diagnostic methods, new concepts of disease, and new methods of therapy will appear rapidly throughout your career. It is a stimulating challenge to you to keep up with these advances."

On social and moral responsibility:

"Another challenge to the physician is the obligation to elevate social and moral standards of his community. Perhaps he is too busy to realize it, but the doctor has a real influence upon the morals and thinking of his community. Because of his intimate relations with his patients, his advice is sought in many matters other than health. And since he is biologically-minded and knows better than any other professional person how the human being functions, the doctor is preëminently well adapted to give advice on moral and ethical matters.

"For such service he is in a very favorable position. Unlike the politician who finds all that he can on the vote-getting side of a question and overlooks the other side, the physician is committed to seek and use the truth. He has to get and use all of the evidence in his work, and this type of thinking is exceedingly desirable in decisions affecting human life and conduct. Hence the physician, by precept, example, and through his teaching, exercises an outstanding influence upon the moral and intellectual pattern of his community."

On the critical attitude:

"...Modern medicine has available many remedies and makes use of many diagnostic aids. There is a strong tendency now for drug houses and other organizations to attempt to do the doctor's thinking for him and thus influence his use of their products. The advertisements and agents are very subtle but the intent is recognizable. The physician owes it to his patients and to himself to be alert, critical, and resistant to the many salesmen of products of unproved therapeutic value.

"There is also great need to be critical of laboratory testing. Medicine now makes use of many laboratory tests. These have their value, but they must be used with discretion. The doctor must know the possibilities and limitations of the tests he uses. To order laboratory work indiscriminately increases the expense to the patient and perhaps confuses the doctor who makes the useless orders. Therefore, you will have to study very seriously the new diagnostic aids and the new therapies, and this means that you will have to be a lifelong student. So your student days are not over. The pressure of immediate examinations is off but the graver examination of your daily work will always be with you."

On professional obligations:

"...You are heir to principles gained through the experience of thousands of your predecessors and you are to have the great opportunity of using the remarkable tools made available to medicine by scientific research. This is a great privilege and you can best repay your debt by payment in kind; that is, by helping to add to the store of medical knowledge and by upholding the ideals of the medical profession."

Dr. Roe concludes his letter as follows: "And now you are on the threshold of a great career. The marvelous instruments of science and the great body of medical knowledge created by scientific research are at your disposal. Your lifework can be a symphony of useful services. You can prevent suffering, lengthen the lives of human beings, and teach people a more harmonious philosophy of life. It is a supreme privilege to lengthen the life of a single individual; yet you are to have this privilege as a daily routine task. This is a stimulating and challenging opportunity. You have worked very hard for this privilege, but you are indeed fortunate."

In a day of rampant materialism this eloquent plea for adherence to the highest ideals of medicine might well be read with profit by every physician. As for the author, the sentiments expressed might be expected from as dedicated and high-minded a person as "Joe" Roe.

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Medical Histrionics

What was billed as "a startling dramatization of medical case histories" was given its *première* in Chicago recently to an audience composed of physicians, medical society officials, and public relations experts employed by medical organizations. The sponsor was NBC, which was unveiling a new series of television dramas known as "Medic."

The first episode concerned a pregnant young wife who, it was discovered, had leukemia. As the "history" unfolded, the utter hopelessness of her situation, its tragedy to her and her loved ones, and the frustration of the medical experts carried an emotional impact that was quite overwhelming. Several of those present at the first showing were obviously deeply moved.

Much care had been taken to assure the film's technical correctness. Except for the principal actors, real life physicians, nurses, and other medical personnel were used, and no one could find fault with the surroundings and technical equipment. However, to heighten dramatic moments, the principal actors were at times "hammy." Perhaps this is quibbling when the over-all excellence of the production is considered.

After the showing there was much discussion about the film and its probable effect. All agreed that from a dramatic standpoint it was terrific. In regard to the medical aspects, there were some reservations. Upon being asked his views, your Observer expressed the opinion that the telecast would be a great success from most viewers' standpoint. He saw little of value in it from an educational point of view; in fact, in this regard it might even cause apprehension in quarters where none existed before.

Upon his return to Washington your Observer heard other reactions which were quite different. One obstetrician called attention to obsolete medical procedures shown in the picture. This, together with the unprofessional behavior of the doctor in the closing sequences, irked her. It will be recalled that the mother died on the operating table and stringent methods had been adopted to revive the all but dead baby. When it was certain that the child would live, the nurse inquired of the doctor if she should tell the husband, who was waiting in the hall outside, that the mother had died. The surgeon replied, "No, tell him that the baby lives." Such behavior, the obstetrician insisted, is shocking, for it is properly the function of the physician, and no one else, to speak personally to the nearest relative under such circumstances. She also protested the negative approach of the picture. Why emphasize medicine's failures when there is a vast store of brilliant accomplishments?

Another physician took an opposite view. He praised the film, which, by the way, was telecast in the Washington area, without reservation. He insisted that from a public relations standpoint nothing could have been more effective.

So it seems that there are varying opinions among doctors in regard to this demonstration of medical histrionics. Some squirm at what they consider unnecessary "hamminess"; others, providing the "show" is technically correct, are concerned only with the effect upon the viewer and listener. As to your Observer, he is of the opinion that real life stories involving physicians and their patients need little dressing up to make them dramatic. When set forth in a documentary manner they carry all the impact required. This is not theory but has been demonstrated on many occasions and through all types of mass communications media.

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The Observer's Lament

There is a Washington physician whom your Observer has long admired for an unusual gift. When he writes for publication, his first draft is his last—no "sweat, blood and tears" for him. He knows what he wishes to say and says it in a lucid, interesting manner. There are no interdelineations, erasures, or corrections. Invariably his copy is clean. Small wonder that he is the despair of his friends who envy his command of the written word. Incidentally, he is equally effective as a speaker.

In contrast, your Observer is a galley slave. He begins the preparation of this column with a rough draft—and it is rough—bearing little resemblance, except for the title, to the finished copy two or three drafts later. Even then he is often not too happy with the result, but deadlines are deadlines and they must be met.

Long ago he resolved not to read what he had written once it appeared in print, for he has learned from sad experience that errors for which he may or may not be responsible blot out all that may otherwise be acceptable. For his peace of mind, therefore, he avoids his column when looking through current issues of the ANNALS. Sometimes he is surprised by a reader who inquires about such and such an item. Often, to his embarrassment, he cannot recall it. Of course, the reader does not know that what appears in a current issue was written several weeks before. Approximately a month passes between the time the copy for the ANNALS is forwarded to the printers and the finished product is in the hands of the readers.

There is one serious flaw in the laborious and ostrich-like course pursued by your Observer, and that is that on occasion he is repetitious. But so long as the readers do not complain, your Observer is content. Someday he may be a one-draft writer himself, but he doubts it.

T. W.

SUGGESTED MEDICAL PROCEDURES FOR THE DIAGNOSIS OF DIABETES

WILLIAM KURSTIN, M.D.

President, Diabetes Association of the District of Columbia, Inc.

Individuals found to have sugar in the urine on screening test are not necessarily diabetics. Hyperthyroidism, liver and pancreatic diseases, and infections may produce glycosuria. It is recognized that the presence of sugar in the urine is not proof of diabetes. It indicates in every case, however, the need for critical analysis including history and general examination, follow-up, and prolonged observation at intervals for life.

It is further recognized that subsequent laboratory tests may be temporarily within normal limits and that a conclusive diagnosis of diabetes cannot be made immediately. In some such cases definite diabetes develops in later years. Because of this fact, it is recommended that any individual who has had sugar in the urine, considered nondiabetic, have his condition rechecked annually.

Sugar in the urine. Sugar found in the urine on screening tests should never be disregarded. The diagnosis of diabetes cannot rest upon this finding alone, but the probability of diabetes is high if a positive test is obtained 2 to 3 hours after a meal containing a large amount of carbohydrate, especially if the individual is overweight or if there is a family history of diabetes.

Blood sugar determinations. The normal range of fasting blood sugar by the Folin-Wu method is generally considered to be between 70 and 110 mg. per 100 c.c. of blood. If the fasting blood sugar level exceeds 130 mg., one must consider this to be strongly suggestive of diabetes. Hyperglycemia 1½ to 2 hours after a meal containing a large amount of carbohydrate is of considerable value in the diagnosis of diabetes, especially when the fasting blood sugar level is normal.

The Folin-Wu method using venous blood and the Folin-Malmros method using capillary blood are commonly used. The determination of true glucose (by the Somogyi or other methods) is preferred by many authorities. It is urged that true glucose methods be adopted wherever possible.

The presence of any amount of glucose in the urine, accompanied by blood sugar values above the following levels, indicates with a high degree of probability the presence of diabetes:

A. Venous blood sugar:
   1. Folin-Wu method—over 130 fasting, over 200 within 3 hours after eating.
   2. Somogyi method, or other methods for true glucose value—over 110 fasting, over 150 after eating.

B. Capillary blood sugar:
   1. Folin-Malmros method—over 140 fasting, over 240 after eating.
   2. True glucose value methods—over 120 fasting, over 200 after eating.

Glucose tolerance tests. Sugar tolerance curves help to determine the presence or absence of diabetes in cases in which other data are inconclusive. In all borderline cases a glucose tolerance test is definitely indicated. The standard oral glucose tolerance test is most usually employed.

Standard oral glucose tolerance technic. The patient must be instructed to have no curtailment of diet 3 days prior to the test. The patient is instructed to report without breakfast and no food following the previous evening meal. A fasting blood sugar determination is made and the urine is voided at the same time and tested for sugar. Immediately following this 100 Gm. of glucose (more specifically, 0.8 Gm. per pound or 1.75 Gm. per kilo body weight) dissolved in a glass of water is given by mouth. Lemon juice may be added for flavor. Venous or capillary blood sugars and urine specimens are then examined ½ hour later, 1, 2, and 3 hours after the ingestion of this mixture. For practical purposes the test at 3 hours may be omitted.

Interpretation. The most important figures in this test are the fasting blood sugar and the blood sugar 2 hours after ingestion. If the fasting blood sugar is between 70 and 110 mg., and the 2-hour blood sugar drops to the level of 120 mg. or lower, diabetes can be excluded. If the fasting blood sugar level, however, is above 120 mg., and the 2-hour blood sugar is above 140 mg., the diagnosis of diabetes can be made. The peak of the curve in this test will have been reached at ½ hour and 1 hour, and many authorities think that if the peak exceeds 170 mg., there is strong evidence that diabetes is present.

SUMMARY

All individuals with positive tests for sugar in the urine should be considered as diabetic until proved otherwise. Such cases should be studied and observed for a long period of time. Blood sugar determinations 2 hours after a specific carbohydrate meal will usually indicate the presence or absence of diabetes. In all doubtful or borderline cases a standard glucose tolerance test is recommended.

Those individuals who show glycosuria on screening examinations, and whose subsequent blood sugar tests, either postprandial blood sugars or glucose tolerance tests, are within the normal range, should be observed at least annually for the possible development of diabetes in the future. This is especially true of individuals who are overweight, over 40 years of age, or have a history of diabetes in the family.

Such simple direct analysis and observation will undoubtedly lead to a diagnosis of diabetes in many mild cases and, consequently, to the early institution of proper care, which may possibly add many years of life and prevent a number of the complications of the disease.

GRIEVANCE COMMITTEE CASE REPORTS

The following report is based on a complaint received recently by the Grievance Committee. While all the facts presented are true, they have been arranged in such a manner as not to embarrass anyone. The sole purpose of this report is to call to the attention of members of the Society, in as graphic a manner as possible, typical complaints with which the Committee must deal. The Committee hopes that they will serve to promote a better understanding of the problems which arise between physicians and patients and how best to solve them, thus building up a better relationship between members of the medical profession and their patients.

Case Report 2

Complaint: Mrs. C complained that her husband went to see Dr. X, an allergist, because of shortness of breath. Two months later, after becoming steadily worse, Mr. C died of an undiagnosed pulmonary malignancy. Mrs. C was incensed that an allergist should attempt such diagnosis and treatment, and also that the diagnosis had not been made before death.

Course: Investigation by the Committee revealed that Mr. C had been referred to Dr. X by another physician because of increasing shortness of breath over a period of about 2 months. The initial examination by Dr. X indicated lung pathology. He soon realized that the condition was not due to an allergy, but on the patient's request and the approval of the physician who had referred him, Dr. X set to work at once to establish the correct diagnosis and to get Mr. C to the proper physician for treatment.

In spite of many and varied examinations by specialists, including several X-ray examinations, a bronchoscopic examination under anesthesia by a thoracic surgeon in a hospital, including a bronchogram, an examination by a cardiologist, an electrocardiogram, and various laboratory procedures including examination of the blood, urine, and sputum, the correct diagnosis was not made during life.

The X-ray examinations showed an infiltrative process in the patients's lungs which it was reported did not indicate tuberculosis, carcinoma or bronchiectasis, but suggested the possibility of lipoid pneumonia.

The bronchoscopic examination revealed findings apparently due to fibrosis. Bronchial washings obtained before a bronchogram was made were negative for neoplastic cells and for tubercle bacilli but showed intracellular oil droplets, though there was no history of recent use of oil nose drops. The bronchoscopist wrote that he was glad that he could rule out bronchogenic carcinoma. A bilateral bronchogram showed bilateral densities in the lungs which could represent lymphangetic spread of carcinoma, tuberculosis, or Boeck's sarcoid, but because of unusual characteristics of the densities, lipoid pneumonia was considered the likely possibility.

All examinations were made by recognized specialists but a definite diagnosis based upon definite findings was never made. Dr. X might have turned Mr. C over to someone else, but hoped for a definite diagnosis, and, in the meantime, continued to treat him. The various studies were spread over a period of about 7 weeks. Mr. C grew worse. Another physician was called and sent him to a hospital, where he died within 48 hours.

An autopsy showed that he had died of carcinoma of the lungs involving both lower lobes.

Naturally, Mrs. C was much upset. In her letter to the Committee, she wrote: "I am certainly under the impression if he had not been chased around so long, at least he would have had a fighting chance."

Conclusion: To the Committee it appeared that Dr. X had acted with propriety throughout his connection with the case. He had endeavored from the beginning to get a correct diagnosis and had exercised care in treating Mr. C. Upon completion of the investigation, a letter was sent to Mrs. C saying:

"It is the feeling of the Committee that Dr. X accepted Mr. C in good faith because he complained of shortness of breath, and that every conceivable effort to establish a diagnosis and institute treatment was made. It is unfortunate that the true diagnosis was not evident until at postmortem examination. In this type of cancer this is not an unusual occurrence."

SOME FACTS ON MEDICAL POPULATION, U. S. A.*

ROBERT S. GILL

The Williams & Wilkins Company, Baltimore, Maryland

In the Directory of the American Medical Association dated 1950, there are said to be some 221,000 names. This, however, includes Canadian physicians and American physicians who live abroad. The number of M.D.'s in the United States in 1950 was 203,933, according to the "Report to the President by the President's Commission on the Health Needs of the Nation" (1952). This memorandum leans heavily for its statistics on this Report.

Not all M.D.'s are in active private practice; only about 75 per cent are. Another 14 per cent are engaged in teaching, research, industrial medicine, public health at county, state and municipal levels, hospital administration, etc. Six per cent are in Federal employ—Veterans Administration, Public Health Service, armed services, etc. Five per cent are retired or inactive as physicians.

General population is growing rapidly and medical population follows general population quite closely. It is true, however, that there are fewer physicians per 100,000 of population today than there were in 1909. The figure then stood at 149 and it dropped steadily for 20 years. In 1929 it stood at 125. The figure then slowly increased to 133 in 1940, at which level it stabilized; i.e., it has ranged between 133 and 136 since 1940.

This behavior of the statistics was doubtless due to the gradual disappearance of the diploma mills after 1908 (when the AMA became really active in standardizing medical education) and the ever-increasing rise in qualifications for the degree of M.D. In 1909, e.g., 7 medical schools were operating in Baltimore and the total enrollment was about 1,400. Now only 2 schools operate and the enrollment approximates 700.

The national average of 133 to 136 physicians to each 100,000 of the population is not evenly spread over the country. In the Central Atlantic and New England states, for instance, the ratio of physicians is 166. This area has more than a third of the Nation's medical schools, besides numerous research institutions; a higher ratio is therefore to be expected.

It is easy to be deluded by general statements about rapid population growth. Our general growth since 1930 is called—and properly so—phenomenal. Yet it amounted to an average of only 1,400,000 per year. For the next 25 years, the predicted annual average increase is 1,700,000—1.13 per cent a year. Medical population during the 1930–1950 span increased 2,500 a year on the average, or 1.3 per cent. This figure may be exceeded in the immediate future because of the inauguration of several new medical schools. But even if it were doubled (which is wholly unlikely), there is not in sight any substantial change in the ratio of physicians to general population.

It is easy to be deluded too by general remarks on the great shift of population to the West Coast. Here again is a population movement fairly described as phenomenal. But the cold statistics show that 80 per cent of the country's population is still on the Eastern seaboard, north and south, and in the Midwest. That percentage stood at 90, fifty years ago. The population of the eleven Western states was 5.4 per cent of the entire population in 1900 when it stood at 4,000,000. In 1940 it had climbed to 14,000-000 and 10.6 per cent. In 1950 it reached 19, 400,000 and 12.8 per cent.

It is also worthy of note that the number of M.D.'s per 100,000 of population is already higher than in any other place in the world, Israel excepted. In Israel it appears probable that the situation is distorted by the newness of the nation and its small population. Israel has 625,000 people and 2,386 M.D.'s or 382 per 100,000. U.S.A. ranks next at 136. Great Britain has 114, Iceland 113, Denmark 105, Canada 104, New Zealand 103. Nowhere else is the score 100 or better. This is not of course conclusive, but it is suggestive. An ever-increasing demand for medical care may require more physicians per 100,000 in years to come; but also the modern physician can take care of more people than in the past, and this efficiency is likely to increase.

SPECIALIZATION

The general feeling that the specialties are growing faster, numerically, than general practioners is borne out statistically. Comparisons were possible between 1940 and 1949. In the former years "all physicians" numbered 175,163; in the latter, 201,279. Dividing the second by the first figure gives a growth factor of 115. Comparative figures for "all specialists" were 36,880 (1940) and 62,688 (1949) or a growth factor of 170.

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* Prepared for publication in the MEDICAL ANNALS from an article which appeared in *The Kalends* of the Waverly Press, Inc., 1954, 33, 7 (March–April).

Not all specialties grow, numerically speaking, at the same pace, and the differences are rather wide. Anesthesiology appears to be attracting more physicians, proportionately, than any other branch. In 1949 there were only 1,231 full-time anesthesiologists. But the growth factor for the preceding decade was 432. Table 1 presents growth factors of the leading specialties. Note the lowly position of Eye-Ear-Nose-Throat and of Public Health. Actually there were fewer Eye-Ear-Nose-Throat men in 1949 than in 1940. The tendency seems to be in the direction of splitting Eye from Ear-Nose-Throat.

TABLE 1

Growth Factor in Specialties, 1949/1940

Anesthesiology	432	
Obstetrics-Gynecology	200	
Psychiatry-Neurology	197	
Internal Medicine	192	
Orthopedics	188	
Ophthalmology	184	
Surgery	182	
Radiology	180	
Pediatrics	180	
Pathology	174	
Pulmonary Diseases	170	
All Specialties		170
Dermatology	165	
Ear-Nose-Throat	131	
Urology	128	
All Physicians		115
Public Health	100	
Eye-Ear-Nose-Throat	97	

How many persons will be engaged in each of the specialties in 1960? Here we can only attempt to project the past into the future by assuming: (1) that the growth factor will be the same in each case for 1950–1960 as it was for 1940–1949; (2) that the growth factor for part-time specialists is the same as that of their full-time counterparts. Doing this, we come up with table 2. Its figures include probably 35,000 or 40,000 part-time specialists as well as groups who are not M.D.'s—see footnotes.

According to the Report to the President referred to above, the number of diplomates in a specialty is not a reliable guide to the number who specialize. E.g., diplomates in Obstetrics-Gynecology are 2,856 in number, but 5,074 M.D.'s limit their practice to that field.

TABLE 2

Predicted Number of Specialists in 1960

Surgery	39,130
Eye	36,433*
Radiology	33,844†
Internal Medicine	26,079
Obstetrics-Gynecology	20,092
Anesthesiology	17,969‡
Pediatrics	10,980
Psychiatry-Neurology	10,521
Ear-Nose-Throat	8,147
Orthopedists	4,595
Urologists	3,580
Pathologists	3,361
Pulmonary Diseases	2,833
Public Health	1,567

* Including about 26,000 optometrists.

† Including about 27,000 technicians (there are 310 schools for technicians).

‡ Including about 9,700 nurse anesthetists (there are 82 schools for nurse anesthetists and they graduate 500 a year).

It is obvious that table 2 does not include a complete list of the specialties but only those of the greatest numerical importance. Between now and 1960 it is entirely possible that some specialty (like neurosurgery) may attract enough men to make it numerically more important than some of those in table 2. It is not inconceivable that a wholly new specialty will arise and become numerically important.

MEDICAL STUDENT POPULATION

Undergraduate medical school population since 1945 has rather sharply increased. For the school year 1952–53 there were 27,688 students in medical schools and schools of the basic sciences in the U. S. Assuming continuation of the trend since 1945, there will be about 30,500 in 1960 and 37,500 in 1975. The 1960 prediction is an increase of about 12 per cent between now and then.

This increase may be accelerated by the impact of several new schools and the fact that 4 of the 2-year schools of basic science are expanding to 4 years: Mississippi, Missouri, North Carolina, and West Virginia. The new schools are Puerto Rico (full 4 years in 1954), University of California at Los Angeles (1955), University of Miami (1956), Yeshiva (first class, 1955). One other, at least, is in the projected stage, University of Florida. New schools have also been talked about in New Jersey, Massachusetts and Connecticut. These ventures might increase the medical student body by 15 per cent over all in 1960.

The Council on Medical Education of the AMA notes a 31 per cent drop in the number of applicants (not applications) for admission into medical schools, 1952 as compared with 1949. However, in 1952 the number accepted (7,425) was less than half the number of applicants (16,763). The demand for medical education continues to exceed the supply. The Council also notes a slightly smaller aggregate freshman class in 1952 as compared with 1951.

TABLE 3

Persons Engaged in Ancillary Medical Services, with Growth Factor, 1949/1940

	Present No.	Growth Factor	Schools	Students
Osteopaths	11,500	109	6	1,750
Dentists	80,000	115	42	12,000
Nurses	366,000	129	1,152	102,000
Chiropodists	7,000	—*	8	1,600
Chiropractors	23,000	112	23	2,900
Optometrists	22,000	119	12	2,300
Veterinarians	15,000	125	17	3,300
Registered Medical Technologists	16,000	267	—*	—*

* Not available.

Scrutiny of medical student population discloses the extremely important part played in American medicine by the faculties of medical schools. These faculties teach many more persons than are regularly enrolled as medical students. Quite aside from some 25,000 students of dentistry, pharmacology, and nursing for whom medical faculties are responsible, there is another 25,000 made up of part-time and special students, non-medical students who take medical courses, doctors taking refresher or continuation courses, doctors preparing to take exams for specialty-board certification, fellows, etc. These groups, with the 28,000 medical students, add up to nearly 80,000 men and women who fall under the tutelage and presumably the influence of the relatively few members of the profession who engage in teaching.

Peripheral Populations

There are several groups of persons, not M.D.'s, who may nevertheless be considered as part of the whole picture of medical population. Most of these are ancillary to medical practice, but some are frankly competitive. Table 3 lists the more important, numerically speaking, of these groups and presents the growth factor of each. The growth factor for M.D.'s (see table 1) is 115. Taking this as par, it will be observed that osteopaths and chiropractors are losing ground numerically. Dentists increase in number about as doctors do. The fastest growing group is that of the medical technologists. The figures given are for registered technologists only. There are about as many more unregistered.

The big group is, of course, the members of the nursing profession. They are about twice as numerous as the actively practicing M.D.'s and the group appears to be growing more rapidly. This is doubtless a desirable state of affairs. Competent and adequate nursing should extend the usefulness and service of the physician.

MEMBERSHIP

The following applicants for membership will be voted on at the meeting of the Executive Board, December 27, 1954.

For Active Membership

Alice N. Bessman, George Washington University—1949
Richard G. Board, Temple University—1947
Thomas F. Cleary, Georgetown University—1953
William S. Cole, University of Virginia—1937
Ralph S. Crawshaw, New York University—1947
Morton C. Creditor, Columbia University—1947
Francis J. Crilley, Jr., George Washington University—1943
Cyril L. Crocker, Howard University—1950
Raymond O. Dart, Rush Medical College—1916
Frank J. DiTraglia, St. Louis University—1943
William Thomas Driebe, Georgetown University—1950
Benedict J. Duffy, Jr., University of Rochester—1944
Leon J. Epstein, University of Tennessee—1949
William R. Felts, Jr., University of Arkansas—1946
Robert J. Fink, Loyola University—1947
James M. Frawley, University of Buffalo—1950
Milton S. Glatt, University of Geneva—1951
Samuel C. Gordon, University of Montpellier, France—1939
Grace H. Guin, Vanderbilt University—1943
William M. Hart, Temple University—1948
William P. Herbst III, Harvard University—1946
James A. Kehoe, Georgetown University—1947

Harry J. Kicherer, George Washington University—1948
William P. McKelway, George Washington University—1950
Louis J. Maciulla, Georgetown University—1950
Albert E. Marland, Jr., Georgetown University—1946
Harry I. Martin, Howard University—1949
Homer B. Matthews, Harvard University—1951
Bertle Nelson, George Washington University—1948
Robert W. Painter, University of Tennessee—1946
Felix D. Paolucci, Georgetown University—1947
J. Winthrop Peabody, Jr., Georgetown University—1948
Theodore R. Pinckney, University of Indiana—1929
Antoinette F. Popovici, University of Bucharest, Rumania—1936
James G. Primm, Howard University—1952
Aurora O. Rivera, University of Philippines—1940
Richard A. Rogers, Northwestern University—1943
Harry Hugh Rosenthal, University of Vienna—1934
Andrew E. Rudnai, Francis Joseph University, Hungary—1937
Sydney G. Salus, Hahnemann Medical College—1950
Melchior F. R. Savarese, Georgetown University—1949
Harold W. Schnaper, Duke University—1948
Eugene D. Schwartz, University of Virginia—1947
Jack P. Segal, George Washington University—1948
Charles D. Shields, Georgetown University—1934
Armando M. Sison, Santo Tomas University—1940
Muriel S. Sowers, George Washington University—1946
Mitchell W. Spellman, Howard University—1944
William M. Trible, George Washington University—1950
John William Winkler, Jr., Georgetown University—1953

For Associate Membership

Joseph D. Connor, George Washington University—1950
Raymond Feldman, Northwestern University—1932
Jean D. Lockhart, Georgetown University—1951
Bennet A. Porter, Jr., George Washington University—1953
Joseph A. Provenzano, George Washington University—1952
William E. L. Stewart, Albany Medical College—1952

For Resident-Intern Membership

Harry N. Carlton, George Washington University—1954
C. Stewart Littwin, George Washington University—1950
Harold I. Passes, University of London, England—1949
James H. Stallings, Jr., George Washington University—1952
Bernard M. Tulley, Harvard University—1951

CONSTRUCTION PLANS FOR NEW HOSPITAL CENTER

General Services Administration, Public Buildings Service, is preparing plans for the construction of the Hospital Center, District of Columbia, which were scheduled for release to bidders the latter part of August, 1954. Contract for preparation of site, grading, sewers and roads has been awarded. The project will require between two and three years to construct at an estimated cost of $17,500,000.

The Hospital Center will consist of three buildings, the Hospital Building, Nurses' Home and Training School, and a building to house Pediatric Facilities for Cerebral Palsy. In the Assembly section of this issue is a picture showing the architect's conception of the Center.

Three District hospitals, Garfield Memorial, Episcopal Eye, Ear, Nose and Throat, and Emergency will be amalgamated and housed in the Hospital Building. Facilities required by each hospital will be consolidated into one building and arranged functionally to unify the supporting facilities to operate for all three units. The facilities required, such as Surgery, Obstetrics, Pathology, Outpatients' Clinic, etc., will be suitably disposed for convenience and general use.

The Nurses' Home and Training School will provide living quarters for student, graduate and staff nurses; also, adequate facilities for social and physical activities, and laboratories, classrooms, and lecture room for advanced study and training.

The third building of this project comprises a treatment and rehabilitation facility for children patients afflicted with cerebral palsy. This building will provide facilities essential to the proper day care of these patients from infancy to seven years of age, together with facilities for training the parents to care for the children when at home. Proper recreation facilities have been provided. This building will have an individual character and will be located in a separate environment from the other two buildings to avoid any possible disturbing influence.

The Hospital Center will be located on a site of approximately 46 acres of rolling land with compatible surroundings in Northwest Washington, adjacent to Soldiers Home, bounded on the south by Michigan Avenue and on the north by the proposed East-West Freeway, affording the public easy access by public transportation or private car.

The main entrance to the Hospital will face north. The approach entrance will be at the intersection of First Street and Michigan Avenue leading to a road system with enclosed landscaped lawn areas, and designed to accommodate free-flowing vehicular traffic. Until completion of the Freeway, which will afford a second entrance, further access to the site will be from Irving Street by means of a temporary road. A service road will connect to, but be separate from the main road system, affording access to the service area, boiler house, garage court, ambulance entrance, and morgue exit.

The site plan provides parking areas for over 1,000 cars, with separate facilities for visitors, employees, and doctors.

In the landscape development of the site special attention has been given to the terrace treatment, both outside of the cafeteria dining room and leading to the recreation area adjacent to the Nurses' Home. The Nurses' Home and Training School will be situated apart from the main Hospital, but connected by a covered passage. It will be surrounded by suitable park areas to afford a pleasant environment.

The structural frame of the buildings will be of reinforced concrete. The exteriors will be faced with brick with limestone trim and entrance motifs. Windows and exterior doors will be of aluminum.

The Hospital Building will have a capacity of 815 beds, serving surgical, medical, obstetric, and psychiatric patients. These beds will be distributed over five nursing floors. The Outpatient Department will have facilities to care for 400 patients daily with normal follow-up service. Quarters for resident physicians and interns will be provided on the sixth floor.

Services for the convenience of patients, staff and visitors will be provided, such as cafeteria, snack bar, gift shop, flower shop, etc.

The mechanical features of the Hospital will be consistent with modern trends, including air conditioning of all patient areas.

HOME OF WASHINGTON PSYCHOANALYTIC SOCIETY DEDICATED

The formal opening of the first building to be owned by the Washington Psychoanalytic Society took place on Saturday, October 2, 1954. The building, situated at 1720 M Street, N.W., immediately adjacent to the Medical Society of the District of Columbia, was open for inspection after ceremonies held in the auditorium of the latter's building.

The program followed a two-fold theme—the historical development of the Washington-Baltimore Psychoanalytic Society, and the unique contributions of Dr. Ernest E. Hadley, charter member of the Washington-Baltimore Society in 1932, who was serving as President of the Washington Society and Director of its Institute at the time of his death on August 10, 1954.

The speakers, introduced by Dr. Mabel B. Cohen, President of the Society, were: Dr. William V. Silverberg, first Director of the Washington-Baltimore Institute; Dr. Lewis B. Hill, who succeeded him in that position; Dr. Edith Weigert, present Director of the Washington Psychoanalytic Institute; and Dr. Leo H. Bartemeier, now a faculty member of the Washington Institute.

The library in the new building will be known as the Ernest E. Hadley Memorial Library. Dr. Hadley's entire collection of psychiatric literature has been presented to the Institute by Mrs. Hadley, and three bequests totaling $4,000 have been received for the purchase of additional psychiatric and psychoanalytic volumes.

The building, newly remodeled and redecorated, is a three-story brick structure. The entire first floor is occupied by the Society and the Institute and includes a small auditorium, the library, the secretary's office, a reception hall, and a small kitchen. Rentals from the second and third floor offices will be used to defray operating expenses.

Following the ceremonies and during the inspection of the building refreshments were served to the members and guests.

The original Washington-Baltimore Psychoanalytic Institute was organized in 1933, with the approval of the American Psychoanalytic Association; a separate institute was established in each city in 1952. At the present time there are 14 such recognized training institutes in the United States. Currently there are 66 graduate physicians enrolled in the Washington Institute as candidates in training in psychoanalysis. The Washington Psychoanalytic Society has a present enrollment of 72 physicians.

On the Lighter Side

There has been a recent dearth of news from our colleagues concerning their nonprofessional activities. This seasonal drought may have been due, we hope, to the change-over from a summer of golf, boating, fishing, etc. to a busy autumn program of medical activity. This column has been waiting with bated breath for news from our summer yachtsmen as to their sailings and moorings. We have anticipated, but never realized, the fullness of the summer's fishing tales—tales that have been told but not to us. We have waited to hear of exciting far-away places seen and visited on the many summer vacation trips. But none have come.

We wonder if our brethren do want confirmation that their tales of prowess and adventure are not akin to boasting, but are of down-to-earth interest to those of us who cannot participate for one reason or another. Some of us do not have the ability or agility to participate, yet we do so, imaginatively, in perusing the adventures of our more fortunate fellows. Please let me repeat—every one of us is interested in the goings-on of our friends, and there is no onus attached to having the tale and the teller profiled in this column. All of us enjoy thoroughly every recounting of the lighter side of the man of medicine; therefore, send to this column all or any events in which you have participated, so that all of us who read the ANNALS can enjoy with you that which you have already enjoyed.

BOWLING NEWS: The D. C. Medical Bowling League is well into its first half season. The League could use a few more strong-armed bowlers in order to balance the League teams that need more manpower. You do not have to be a major or minor league bowler to qualify. The majority of the pinspillers have averages in the nineties, a good many in the eighties, and a few in the seventies, but all members have fun regardless of their individual averages. Therefore, if you want an evening of relaxation, fun, and good sportsmanship join the D. C. Medical Bowling League by phoning the secretary, Mr. William (Barney) Cochrane at Randolph 6-3159.

The first month of bowling revealed the following statistics:

STANDINGS

Team	W	L	HiG	HiSet	Team	W	L	HiG	HiSet
1. Doctors	9	3	537	1545	9. Prince George	7	5	530	1523
2. George Washington	8	4	551	1594	10. Georgetown	6	6	548	1529
3. Casualty	8	4	561	1587	11. Suburban	4	8	555	1586
4. Sibley #1	8	4	547	1553	12. Wash. Hospital Center	4	8	526	1522
5. Children's	8	4	558	1599	13. Providence	4	8	544	1547
6. Sibley #2	7	5	543	1523	14. Emergency #1	4	8	520	1486
7. Columbia	7	5	519	1522	15. Emergency #2	4	8	549	1434
8. Garfield	7	5	532	1489	16. Good Hopers	1	11	516	1518

TEAM MEMBERS AND THEIR AVERAGES

DOCTORS

Dr. W. Robert Perkins, *Captain*—102
Dr. Ray N. Brown—101
Dr. Benjamin Golden—97
Dr. Leland S. Madden—91
Dr. William J. Evans—90
Mr. James Carter—90

CASUALTY

Dr. Alfred Dibbs, *Captain*—98
Dr. John P. D'Angelo—103
Dr. Henry H. Canton—100
Mr. Kenneth Clark—107
Mr. Paul Duffy—113

CHILDREN'S

Dr. Frank S. Bacon, *Captain*—91
Dr. Ambrose H. Cook—99
Dr. Thomas J. Pekin—97
Dr. Israel Kessler—96
Dr. George Resta—94

COLUMBIA

Dr. J. Earl Kadan, *Captain*—106
Dr. Clyde P. Reeves—104
Dr. A. J. Connolly—94
Dr. James M. Frawley—86
Mr. Irwin T. Sealfon—91

PRINCE GEORGES

Dr. Frederick E. Musser, *Captain*—107
Dr. William Brainin—102
Dr. Charles Hageage—102

Dr. John W. Perkins—98
Dr. Harry Ferris—93
Dr. Leonard S. Berman—93
Mr. Kendell Twigg—102

Suburban

Dr. Andrew J. Betz, *Captain*—104
Dr. Millard F. Ottman—107
Dr. James B. Faris—102
Dr. G. Roland Gable—99
Dr. S. Paul Porton—100
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Providence

Dr. J. Garrett Reilly, *Captain*—95
Dr. Alan R. Crain—109
Dr. Harold Heiges—94
Dr. John Haberlin—87
Dr. Eugene MacDonald—85

Emergency #2

Dr. Hamilton P. Dorman, *Captain*—96
Dr. Thomas G. Edison—98
Dr. Harold W. Hawfield—97
Dr. Otto T. Englehart—96
Dr. James A. Sowers—93
Dr. Frank E. Gibson—92

George Washington

Dr. John W. Price, *Captain*—109
Dr. Bernard A. Fitzgerald—109
Dr. Blaine H. Eig—108

Dr. Harry A. Horstman—90
Dr. James A. Roberts—90
Dr. William R. Moses—74
Mr. Frank Baiers—113

Sibley #1

Dr. Francis X. Richardson, *Captain*—107
Dr. George L. Ball—111
Dr. Joseph F. Belair—102
Dr. William H. Clements—100
Dr. John F. Finnegan—98
Dr. Richard J. McNulty—94

Sibley #2

Dr. George H. McLain, *Captain*—97
Dr. J. Phelps Hand—105
Dr. Willis B. Morse—102
Dr. Raymond C. Kirchner—100
Dr. Sollie Katzman—98
Dr. Ralph W. Barnhard—93

Garfield

Dr. Ashby W. Smith, *Captain*—99
Dr. Elmer Klein—101
Dr. Duane C. Richtmeyer—101
Dr. William G. Cushard—96
Mr. John E. Grubb—101

Georgetown

Dr. Gordon R. MacDonald, *Captain*—103
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Dr. Lawrence A. Rapee—100

Dr. Dee R. Parkinson—98
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Dr. David Johnsen—94
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Dr. Maurice Van Kinsbergen, *Captain*—100
Dr. Samuel Zola—105
Dr. Russell S. Page, Jr.—100
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Dr. Robert R. Montgomery, *Captain*—99
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Good Hopers

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1. Dr. Blaine H. Eig	29
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1. Mr. Paul Duffy	387
2. Dr. Gordon MacDonald	370
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High Game

1. Dr. Gordon MacDonald	151
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2. Dr. Gordon MacDonald	10
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J. Earl Kadan, M.D.

WOMAN'S AUXILIARY NEWS

The Woman's Auxiliary to the Medical Society of the District of Columbia held its first regular meeting, October 13, at 11 a.m., in the Medical Society's building at 1718 M Street, N.W.

Dr. Preston A. McLendon, President of the Medical Society, came to say "Thank You" and to tell the Auxiliary members the important part they play as sympathetic listeners and understanding audiences for their husbands. He praised them for the assistance they had given the Society in entertaining visiting societies. It is traditional that an invitation to the District is always accepted, one reason being the graciousness of the Auxiliary members who act as hostesses.

The Shoreham Hat Shop presented a fall hat show with the Auxiliary members as models ('til we got our bifocals adjusted we thought they were from Paris, courtesy of T.W.A.!). The "old hats" and "funny hats" were then displayed. (Isn't it surprising what is in that old trunk in the attic?) Monsieur Jacques (with his "honey chile," "you-all" for Southern appeal) drew numbers from a hat—and guess what? There were lovely hats given as prizes!

The women were reminded of the forthcoming meeting with the Medical Society of Virginia. A "Coffee Hour" is planned for Monday, November 1, for the wives of the visiting doctors, and Tuesday night's dinner and floor show (by the Medical Society members) will be a gala affair.

It was a very gay and pleasant meeting, with the usual excellent luncheon served following adjournment. And the ladies chatted and lingered on—and on!

Mrs. Duane Richtmeyer, President of the Auxiliary, announced the following chairmen to serve for the ensuing year:

Membership: Mrs. Ashby Smith
Program: Mrs. Hugh O. House
Finance: Mrs. George H. Crofton
Social: Mrs. Roger S. Williams
House: Mrs. Charles W. Tegge
Public Relations: Mrs. Clayton H. Hixson
Philanthropic: Mrs. Herbert S. Gates
Educational: Mrs. W. Ross Morris
Legislative: Mrs. G. Louis Weller
Publicity: Mrs. Albert E. Marland

MRS. ALBERT E. MARLAND
Publicity Chairman

BOOKS RECEIVED

Acknowledgment is made of the following books which have recently been received. Selections will be made for more extensive review in the interests of our readers and as space permits. Physicians are urged to submit reviews of additional current books which, in their opinion, merit comment.

The Rauwolfia Story: From Primitive Medicine to Alkaloidal Therapy. Pp. 63. Summit, N. J.: Ciba Pharmaceutical Products, 1954.

Clinical Aspects of the Autonomic Nervous System. L. A. GILLILAN, PH.D., M.D., Associate Professor of Anatomy, Graduate School of Medicine, University of Pennsylvania. Price, $6.50. Pp. 316, with 42 illustrations by the author. Boston: Little, 1954.

The Manual of Antibiotics, 1954–1955. Preparations, Therapeutic Index, Generic and Trade Names, Producers. Prepared under the editorial direction of HENRY WELCH, PH.D. Price, $2.50 ($2.00 to members in good standing of A.Ph.A.) Pp. 87. Washington: American Pharmaceutical Association, 1954.

The Microphysical World. WILLIAM WILSON, PH. D. (Leipzig), D.SC. (London), F.R.S., Fellow of King's College, London, and Professor Emeritus of Physics in the University of London. Price, $3.75. Pp. 216. New York: Philosophical Library, 1954.

A Ciba Foundation-Symposium: The Spinal Cord. G. E. W. WOLSTENHOLME, O.B.E., M.A., M.B., B.CH., *Editor.* Assisted by JESSIE S. FREEMAN, M.B., S.B., D.P.H. J. L. MALCOLM, M.B., CH.B., B.MED.SC., AND J. A. B. GRAY, M.A., M.B., B.CHIR., *Consulting Editors.* Price, $6.50. Pp. 300, with 112 illustrations. Boston: Little, 1953. **Mammalian Germ Cells.** G. E. W. WOLSTENHOLME, O.B.E., M.A., M.B., B.CH., *Editor.* Assisted by MARGARET P. CAMERON, M.A., A.B.L.S., AND JESSIE S. FREEMAN, M.B., B.S., D.P.H. Price, $6.75. Pp. 302, with 54 illustrations. Boston: Little, 1953. **Preservation and Transplantation of Normal Tissues.** G. E. W. WOLSTENHOLME, O.B.E., M.A., M.B., B.CH., AND MARGARET P. CAMERON, M.A., A.B.L.S., *Editors.* Assisted by JOAN ETHERINGTON. Price, $6.00. Pp. 236, with 55 illustrations. Boston: Little, 1954. **The Chemical Structure of Proteins.** G. E. W. WOLSTENHOLME, O. B. E., M.A., M.B., B.CH., AND MARGARET P. CAMERON, M.A., A.B.L.S., *Editors.* Price, $6.00. Pp. 222, with 49 illustrations. Boston: Little, 1954.

News and Personals

MEETINGS—Past and Future

The Association of Military Surgeons of the United States will hold its 61st Annual Convention at the Hotel Statler, November 28–December 1. Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, who is President of the Association, will preside at the opening scientific session, November 29, at which time he will deliver his Presidential Address. "The Role of the Army in the Maintenance of National Health" will be the subject presented at the first session by Major General George E. Armstrong, Surgeon General of the Army. Rear Admiral Lamont Pugh, Surgeon General of the Navy, Major General Dan C. Ogle, Surgeon General of the Air Force, and Vice Admiral Joel T. Boone, Medical Director of the Veterans Administration, will present the same general topic, each one in relation to the Department he heads.

Dr. Harvey J. Tompkins, Director, Psychiatry and Neurology Service, Veterans Administration, will participate in a Panel Discussion on Preventive Psychiatry, November 30. His topic will be "Korean Veterans with Psychiatric Disabilities." Dr. Edward Freis, of the Veterans Administration Hospital, will present a paper, December 1, on "Recent Advances in Chemotherapy of Hypertension." Dr. Clifton K. Himmelsbach, Assistant Chief, Division of Hospitals, USPHS, will be a panel discussant, December 1, on the subject, "Pharmaceutical Aspects Involved in Accreditation of Hospitals."

The Washington Academy of Surgery announces its guest speaker for the next meeting, December 13, as Dr. J. William Hinton, Professor of Surgery, New York Postgraduate Medical School. Dr. Hinton will address the members and their guests on "The Mechanism and Action of Antithyroid Drugs and Their Role in Thyroid Crises." As usual, this will be a dinner meeting at the Kennedy Warren; the time, 7 p.m. Dr. W. Ross Morris, President of the Academy, will preside at the meeting.

PROGRAM
THE MEDICAL SOCIETY OF THE
DISTRICT OF COLUMBIA
1718 M Street, N.W.

December 8, 1954, 8:15 p. m.

THE THERAPY OF DISABILITY

JOSEPHINE BUCHANAN, M.D., *Moderator*
Chief of Physical Medicine and Rehabilitation,
District of Columbia General Hospital

Panel participants to be announced.

A feature of the program will be patient demonstration. Physicians' wives are cordially invited to attend this meeting.

The first fall meeting of the **D. C. Chapter of the American Federation for Clinical Research** was held in the library of the Medical Society's building on October 11. The following program was presented:

"A Comparison of the Effects of Intravenous and Oral Fat on the Repletion of Malnourished Humans," Drs. Morton C. Creditor and Stanley M. Levenson, Walter Reed Army Medical Center

"Cardiovascular Responses to Hypothermia," Drs. D. C. Sabiston, Jr., E. O. Theilen, and D. E. Gregg, Army Medical Center Graduate School, Walter Reed Army Medical Center

"Uptake of Ammonia by the Brain in Hepatic Coma," Drs. Alice N. Bessman and Samuel T. Bessman, D. C. General and Children's Hospitals

"Specific Therapy for Salicylate Poisoning," Drs. George E. Schreiner, Leonard B. Berman, John Griffin, and Jean Feys, Georgetown University Hospital

"Effect of Phenylbutazone on Uric Acid Metabolism in Normal Subjects," Dr. James B. Wyngaarden, National Institute for Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda, Md.

The American Occupational Therapy Association held its 37th Annual Conference at the Shoreham Hotel, October 16–23. The general theme of the Conference was "Capitalize Your Assets."

At the sectional meeting on Tuberculosis, October 21, Dr. Moe Weiss, Chief of the Medical Service at Glenn Dale Hospital; Dr. Howard M. Payne, Professor of Medicine, Howard University School of Medicine; Dr. David Leibovici, Chief Medical Officer, Upshur Street Hospital, and others participated. Dr. Reginald T. Lourie, Chief of the Psychiatric and Child Guidance Department, Children's Hospital, spoke on "Emotional Problems of Children" at a sectional meeting on Psychiatry, October 21.

Members of the Medical Society and their wives heard a discussion on Nostrums and Quackery at the **Society's first meeting,** October 13. A number of fraudulent devices were on exhibit and attracted considerable interest and amusement. Staff members of the Division of Medicine of the Food and Drug Administration presented the following program:

"Devices and Delusions," Dr. Irvin Kerlan, Medical Officer

"Cancer Quackery," Dr. Gordon A. Granger, Medical Officer

"What Is a New Drug?" Dr. Ralph G. Smith, Chief, New Drug Branch

"Your Problems and Ours," Dr. Albert H. Holland, Jr., Medical Director.

The Clinical Society of the Diabetes Association of the District of Columbia held a meeting in the library of the Medical Society's building on October 28. The guest speaker was Dr. Wilbur A. Duryee, Professor of Clinical Medicine, New York University Postgraduate Division; he spoke on "Peripheral Vascular Disease in the Diabetic." Dr. Duryee is also Chief of the Vascular Clinic of New York Postgraduate Hospital and Chairman of the Section on Circulation of the American Heart Association.

A dinner meeting, to which all ophthalmologists in the vicinity of Washington were invited, was sponsored by the **Section on Ophthalmology** at the Kennedy-Warren, October 12. The guest speaker, Dr. Frank Payne, of New York, discussed "Unilateral Retrobulbar Neuropathy due to Intracranial Tumors."

The Jacobi Medical Society met, October 18, at the Washington Hotel. Following dinner, the members heard an address on "The American Political Scene Today" by Mr. Max Freedman, foreign correspondent.

The Section on General Practice met at the Kennedy-Warren, October 26. A paper on the "Emotional Problems of the Adolescent" was presented by **Dr. Hugh H. Hussey,** Editor of GP and Professor of Preventive Medicine at Georgetown University School of Medicine.

At a special business meeting of the **Washington Psychoanalytic Society,** September 17, following the death of its President, Dr. Ernest E. Hadley, Dr. Mabel B. Cohen was elected successor.

On September 22, the Education Committee of the Washington Psychoanalytic Institute, the teaching unit of the Society, elected the following officers: Dr. Edith Weigert, Director of the Institute; Dr. Robert A. Cohen, Chairman, and Dr. Alexander Halperin, Secretary, of the Committee. Dr. Stanley L. Olinick will continue as Treasurer of the Institute.

Drs. Weigert and Cohen were elected Fellows of the Board of Professonal Standards, with Drs. Rex E. Buxton and Robert T. Morse to serve as alternates.

GENERAL NEWS

At the regular meeting of the **Executive Board of the Medical Society of the District of Columbia,** September 27, formal endorsement was given to the program for the control of poison ingestion being developed by the D. C. Chapter of the American Academy of Pediatrics (see editorial by Dr. Coleman in this issue of the Medical Annals).

The Board approved the recommendation of the Committee on Public Information that Television Station WTOP-TV be given the John Benjamin Nichols Award for its outstanding contributions to the health of the community.

President McLendon submitted the following appointments, which received the approval of the Board:

Dr. J. Ross Veal, to membership on the Public

Welfare Advisory Council, which appointment was made at the request of the District Commissioners following the resignation of Dr. Montgomery Blair.

Dr. Edgar E. Quayle, to the D. C. Commisioners' Citizens' Advisory Council on the Housing Code.

Dr. Isadore Levin, to the Classification Committee.

The American Medical Women's Association, Inc. is compiling a list of all part-time positions open to or held by women physicians in the United States. With such a list women doctors with families who have or anticipate having some free time could be alert to possible opportunities. Since this is to be a permanent file, it should include all part-time positions, not just those now vacant.

The Women's Medical Society of the District of Columbia is assembling this information for the Greater Washington Metropolitan Area. If it is to be complete, the assistance of all physicians in this vicinity is needed. Physicians who know of any such position are asked to please send a note, or to phone the office of Dr. Elizabeth S. Kahler, Chairman, Fellowship Committee, 3828 Fulton Street, N.W., Washington 7, D. C., telephone Woodley 6-1264.

The Women's Medical Society also wishes to express, through the columns of the MEDICAL ANNALS, its appreciation to the Medical Society and to the ANNALS for the publicity given this project.

Dr. George E. Schreiner, President of the **Washington, D. C. Chapter of the American Federation for Clinical Research,** writes the Secretary of the District Medical Society as follows:

> "Cross-fertilization has long been considered one of the more rewarding technics of scientific investigation when it is used in a busy scientific community. Obviously, some pollen must go along with the wind. Washington has been fortunate in witnessing a tremendous expansion of medical research facilities and a large increase in the population of medical investigators. These men are distributed through the universities, the hospitals, the military facilities, the Public Health Service, the Veterans Administration, and other agencies of our Government.
>
> "At present the only effective organization open to all medical investigators in the District of Columbia and offering a forum for the presentation of work-in-progress is the Washington, D. C. Chapter of the American Federation for Clinical Research."

Dr. Schreiner urges all investigators in the D. C. Medical Society to join the local chapter of the AFCR. Applications may be sent to Dr. Alvin Parrish, Veterans Administration (Mount Alto) Hospital. Investigators are also invited to submit abstracts for the scientific programs. These should be sent to Dr. Thomas Kennedy, National Institute of Health, Bethesda, Md.

The George Washington University School of Medicine held its 131st opening exercises, September 20, at the School of Medicine. There are 363 students enrolled in the Medical School for 1954–55, of which 103 are freshmen, the largest freshman class in the history of the School. Brigadier General Elbert DeCoursey, Director of the Armed Forces Institute of Pathology, gave the principal address; his subject was "Living in This Atomic Age."

The opening ceremonies were attended by medical leaders from the armed forces, Public Health officials, and other representatives of governmental and private medical services. Dr. Walter A. Bloedorn, Dean of the School of Medicine, was host to faculty members and distinguished guests at a luncheon at the Mayflower Hotel.

The District of Columbia Division of the American Cancer Society announced two grants to local institutions on October 1. The sum of $35,000 was awarded the **George Washington University School of Medicine** for 1954–55. The presentation was made by Frederick P. H. Siddons, President of the D. C. Division, to Dr. Cloyd H. Marvin, President of the University. Among those present to accept the gift was Dr. Calvin T. Klopp, Director of the University Cancer Clinic and Secretary of the D. C. Division, ACS. The purpose of the grant is for a wide range of studies in both clinical and basic fields.

A grant of $9,700 was made to the **Visiting Nurse Association** for bedside treatment of cancer patients in Washington. The grant was the highest ever made to the Visiting Nurses by the Cancer Society. Last year the amount was $5,200.

Garfield Memorial Hospital has installed 26 air-conditioning units of various sizes in private and semi-private rooms. Patients requesting the service are assigned to air-conditioned rooms at an additonal daily charge of $3 for private and $2 for semi-private rooms.

The following members of the District Medical Society have been appointed to the **visiting staff of St. Elizabeth's Hospital** during 1954:

Dr. Jeanne C. Bateman, Consultant in Medical Oncology
Dr. Jack L. Derzavis, Visiting Dermatologist
Dr. Morris S. Schwartz, Visiting Sociologist
Dr. Stanley L. Olinick, Visiting Psychiatrist
Dr. Thomas C. Thompson, Visiting Urologist

Copies of the group photograph of members of the Medical Society of the District of Columbia are now available at $22.50 each. The composites are sized 16½ by 32 inches and are available in folder or in stiff back style for framing. Orders for the group photograph should be placed with Miss Hall, News Department, Harris & Ewing, 1313 F Street, N.W., telephone National 8-8700.

Attention of Medical Society members is directed to an interesting series of ads which **Peoples Drug Stores, Inc.** is running currently in the *Washington Star*. The first ad appeared on October 5 and subsequent ads will appear each Tuesday. The advertisements, which are captioned "Capsules," are designed to appeal to the consumer and to further the idea that health requires three-way teamwork on the part of "you, your doctor and your pharmacist." The first Capsule, October 5, concerned narcotic prescriptions.

Mr. Isadore Seeman has been named **Executive Director of United Community Services,** succeeding Mr. Ferdinand V. Grayson, who resigned in July to become Executive Director of the Community Chest Federation. Mr. Seeman has been serving as Acting Director.

Mr. Seeman came to UCS in 1949 as Secretary of the Health Section. In 1952 he was promoted to Assistant Executive Director and Budget Director of UCS. He is a graduate of State Teachers College in Towson, Md., and has a degree in health education from Columbia University and a Master of Public Health degree from the University of Michigan. He has served as statistician with the American Public Health Association in New York, as Director of the Bureau of Vital Records of the Baltimore Health Department, and as Director of Health Information for that department.

PERSONALS

Dr. Edgar P. Copeland, whose resignation as Chief of the Medical Staff of Children's Hospital was reported in the August ANNALS, was honored by more than 300 colleagues and friends at a reception at the Hospital the evening of October 18. The occasion also marked the golden wedding anniversary of Dr. and Mrs. Copeland. A gold clock inscribed with their names and the years "1904–1954" was presented to them as a remembrance of the occasion. Dr. Copeland is continuing his private practice and the ANNALS staff joins his many friends in wishes for continued health and happiness in the years ahead.

Dr. Copeland has called attention to an error in the previous item, i.e., that he was Chief Pediatrician at Columbia Hospital. Dr. Copeland served in that capacity from 1935 until he relinquished those duties in 1951. Dr. Harold M. Hobart succeeded him at that time and Dr. Copeland was appointed to the Medical Advisory Staff, which appointment he still holds. The error is regretted and the ANNALS staff is pleased to make this correction.

Dr. Seymour Alpert, Assistant Professor of Anesthesiology, George Washington University School of Medicine, presented a paper on "The Place of Chlorpromazine in Anesthesia" as part of a Symposium on Clinical Research in Anesthesia, October 27, during the annual meeting of the American Society of Anesthesiologists in Cincinnati, Ohio, October 25–29. Co-authors of the paper were **Dr. Charles S. Coakley**, Director of Anesthesiology, George Washington University Hospital, Dr. William A. Spencer, George Washington University School of Medicine, and Dr. Murray Finkelstein, Veterans Administration Hospital, Martinsburg, West Virginia.

Dr. Edgar W. Davis, Professor of Thoracic Surgery, Georgetown University School of Medicine, addressed two important meetings held in Washington in September. On September 15, at the Second World Congress on Cardiology, he spoke and showed a movie on "Surgical Technics of Intra-auricular Septal Defects under Hypothermia." He presented a paper, September 21, before the American Roentgen Ray Society on "Surgical Procedures in the Diagnosis and Treatment of Bronchogenic Carcinoma."

Dr. Bernard J. Walsh has been appointed Chairman of the Program Committee of the Council on Rheumatic Fever and Congenital Heart Disease of the American Heart Association. The Association will hold its next annual meeting in New Orleans in October, 1955. Dr. Walsh is also a member of the Board of Directors of the National Association as well as of the Washington Association.

Drs. Leonard T. Peterson and Robert H. Barter, both on the staff of George Washington University School of Medicine, were invited to participate in the program of the Pan Pacific Surgical Congress, which was held in Honolulu, Hawaii, October 7–18. Dr. Peterson, who is Assistant Clinical Professor of Orthopedic Surgery, spoke on "Fractures of the Hip: Treatment Including Prostheses." Dr. Barter, Associate Professor of Obstetrics and Gynecology, gave an address on "Current Concepts of Ovarian Surgery."

Dr. Wallace M. Yater, a regent of the American College of Physicians, was guest speaker at the Kentucky Regional Meeting of the College in Lexington, October 16. "A Glimpse of the Early History of the College and a Summary of Its Activities and Accomplishments" was the subject of his address.

Dr. Louis K. Alpert, Chairman of the national Diabetes Detection Week, has been appointed Governor for the District of Columbia of the American Diabetes Association. The Board of Governors was recently established by the Association in order to stimulate interest in diabetes and related conditions, as well as to facilitate coördination of such activities.

Dr. Roy Hertz, of the National Cancer Institute, Bethesda, Md., participated in a special two-day scientific session, October 18–19, on Cancer of the Uterus: A Critical Appraisal of the Problem. This session was a special feature of the Annual Meeting of the American Cancer Society in New York, October 17–22. Dr. Hertz contributed to the program a paper on "Endocrinological Background of Patients with Endometrial Hyperplasia or Cancer of the Fundus."

Dr. Edward J. Stieglitz participated, September 9, in a Panel Discussion on Geriatrics before the American Congress of Physical Medicine and Rehabilitation at the Hotel Statler.

Dr. Stieglitz was in Princeton, New Jersey, September 15, where he gave the evening address at the Second Annual Institute of the New Jersey Neuropsychiatric Institute. He spoke on "Predictable Stresses in Later Maturity."

He was chosen to give the William Royal Stokes Memorial Lecture of the Medical and Chirurgical Faculty of the State of Maryland at its semi-annual meeting in Hagerstown, Md., September 30. "Difficulties in Geriatric Diagnosis" was the title of his lecture.

Drs. Milton C. Cobey and Robert C. Rush have withdrawn from the firm of Drs. Talbot, Larkin and Cobey at 1835 Eye Street, N.W., and will be associated in the practice of orthopedic surgery at 1726 Eye Street, N.W.

Drs. J. A. Talbot, William J. Tobin and Marvin M. Gibson will continue their association at 1835 Eye Street, N.W.

Dr. Carl Berg announces his association in the practice of orthopedic surgery with Drs. Talbot, Tobin and Gibson at 1835 Eye Street, N.W.

Dr. Theresa Ting Woo is the recipient of a postgraduate scholarship awarded by Harvard University School of Public Health to prospective public health leaders. The scholarships, 14 in number, were the first to be granted by the School since its inception 41 years ago.

Dr. Woo received her medical degree from the University of Michigan School of Medicine in 1934. She has taken postgraduate study at the University of Chicago and at the School of Tropical Medicine of the Army Medical Center. During World War II she served in the Medical Corps of the U. S. Army as a research analyst in the Medical Intelligence Division of the Surgeon General's Office. Following the war she maintained an office in the

District of Columbia for the practice of pediatrics. Later she returned to Army duty and, commissioned Major, served in the Army Hospital at Fort Belvoir, Virginia.

Dr. Eleanor Short has been promoted from staff psychiatrist to Assistant Director of the Alcoholic Rehabilitation Division of the District Health Department.

Dr. Short received her medical training at the Pennsylvania State University and Temple University School of Medicine. As staff psychiatrist at St. Elizabeths Hospital, she completed her psychiatric residency training. In January, 1950, she was appointed staff psychiatrist for the newly established Alcoholic Rehabilitation program.

Dr. Eugene J. McDonald, Chief of Radiology at Columbia Hospital for Women, will address the North American Radiological Society in Los Angeles, California, December 8, on "Placental Localization by X-ray."

Dr. Clayton B. Ethridge, Chairman of the Scientific Council, Washington Heart Association, **and Dr. Edgar W. Davis,** Professor of Thoracic Surgery, Georgetown University School of Medicine, took part in a one-day conference for nurses which was sponsored by the Washington Heart Association. The conference was held in the Clinical Center of the National Institutes of Health in Bethesda, October 6.

Dr. Raymond A. Osbourn was elected Vice President, representing medicine, of the Georgetown Club of Washington, September 25. **Dr. William B. Walsh** was elected Governor of the Club, representing the School of Medicine.

Dr. Milton C. Cobey, Professor of Orthopedic Surgery at Georgetown University School of Medicine, was a guest speaker at the 1954 meeting of the Kentucky State Medical Society in Louisville, September 23. Dr. Cobey spoke on "Low Back Pain and Its Related Conditions," with particular reference to the lumbar disc.

Dr. Harold Jeghers, Professor and Director of the Department of Medicine, Georgetown University School of Medicine, addressed the New England Medical Center of Boston, Mass., August 9, on the subject of "Gastrointestinal Bleeding." On August 12 and 19 he lectured at Boston City Hospital on the topics, "Hematemesis and Melena" and "Hemoptysis."

Dr. A. B. C. Knudson has been elected Second Vice President of the American Congress of Physical Medicine and Rehabilitation. Election of officers was held during the 32nd Annual Scientific and Clinical Session at the Hotel Statler, September 6–11.

Dr. James A. Dusbabek was in Salt Lake City, Utah, September 9, where he addressed the Utah Chapter of the American Academy of General Practice on "Use and Abuse of Hormone Therapy in Females."

Rear Admiral Lamont Pugh, Surgeon General of the Navy, addressed the Columbia Medical Society in Columbia, South Carolina, October 11, on the subject, "What the Future of Medicine Is in Relation to the Services."

Dr. Walter Freeman, Past President of the District Medical Society, presented the Library of Congress with a bound volume of reprints of articles written by him during the period, 1936 to 1954, in the field of lobotomy. In acknowledging receipt of this volume in the *Armed Forces Medical Library News*, the *News* quoted with some pride Dr. Freeman's inscription in the complimentary volume: "In sending this incomplete record of work done, I wish to pay tribute to the abundant assistance given by the staff of the greatest medical library in the world."

Dr. J. Winthrop Peabody, Jr. presented a paper on "Dual Granulomatous Disease due to the Deep Mycoses Coëxisting with Active Pulmonary Tuberculosis" before the Annual Meeting of the Southern Trudeau Society in Atlanta, Georgia, September 10.

Dr. B. Edwin Erikson, an Associate member of the District Medical Society, has been elected President of the Middle Atlantic Society of Orthodontists.

Captain William G. Pogue, MC, USA, recently elected to Active membership in the Medical

Society, left for service in the Army Medical Corps, October 19. He is stationed at Fort Sam Houston, San Antonio, Texas.

Three removals from Washington are reported:

Dr. George J. Fleury, Jr. is now in private practice in Newport Beach, California, which is about 40 miles south of Los Angeles. His address is 3420 Via Oporto.

Dr. Franklin D. Hendricks, formerly of 760 Rock Creek Church Road, N.W., has moved to Clearfield, Utah. His address is 39 South State Street.

Dr. Arthur R. Bergman, of Silver Spring, Maryland, an Associate member of the District Medical Society, is now living in the French Cameroun, West Africa, where he is fulfilling a missionary assignment for the Seventh-Day Adventists.

CORRESPONDENCE

Dr. Kinsey Replies to Dr. Prentiss Willson, Sr.

Bloomington, Indiana, August 3, 1954

Dear Dr. Willson:

I have been traveling most of the time lately and have only now had a chance to read your review[1] on our two volumes on human sexual behavior. I want to thank you for the encouragement you give us. It is, frankly, a counteractive to the endless amount of pointless criticism we have gotten from so many quarters, including some medical groups.

I owe it to you to explain that the contraceptive data were gathered on each of the histories and will constitute the material for a special report which the Planned Parenthood Federation has asked us to work up. Our data on fertility and sterility will constitute another very important volume of material. All of this inevitably correlates with the things that we have published, but it is physically impossible to put more than a certain amount of material between the covers of one book. I hope our further publications will serve you.

Alfred C. Kinsey
Professor of Zoölogy, Institute for
Sex Research, Inc., Indiana University

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[1] Willson, P.: M. Ann. District of Columbia, 1954, **23**, 163.

Washington, D. C., October 20, 1954

To the Editor:

It is apparent that doctors and physicians are neglecting to inform theatre personnel of their presence upon entering theatres in this area.

Their office and/or the Medical Bureau is always notified as to their whereabouts and it is very unpleasant to distract an entire audience because of one's shortcomings.

There is absolutely no objection on our part to calling a doctor to the telephone, or even letting him use our phone, if we know where to locate him. We respect his patronage and fully understand his obligation to his patients.

I would like you to publicize this fact in order that there will be more coöperation between all concerned—for better and faster service.

Sincerely,
Bob Carroll
Manager, Ontario Theatre,
Kogod-Burka Theatres

BOOK REVIEW

Abstracts on Military and Aviation Ophthalmology and Visual Sciences, Volumes I and II. Conrad Berens, M.D., New York, and L. Benjamin Sheppard, M.D., Richmond, Virginia. Price, each, $20.00. Pp. 539 and 425, respectively. Washington: Biological Sciences Foundation, Ltd., 1953.

These valuable reference works represent a compilation of all published works of interest to military and aviation ophthalmology from earliest times through the year 1945. Volume I covers the literature through 1940. Volume II covers the years 1941 through 1945. A comprehensive table of contents breaks the subject matter into 93 main divisions and numerous subdivisions. Reference to this table enables the reader to find material on his subject of interest with great rapidity.

The abstracts are well written and show a fine sense of proportion in recording the meat of each article. It is hoped that this valuable work will be kept up to date by the publication of subsequent volumes. The abstracts will be of tremendous assistance to anyone interested in teaching and research.

William M. Hart, M.D.

RICHARD AUGUSTINE KEARNY, M.Ph., M.D., F.A.C.S.

(1883–1954)

Dr. Richard A. Kearny, well known otolaryngologist, died, October 4, 1954, at his home, 2821 Chesterfield Place, N.W., following an illness of several months. He had practiced in Washington since 1921. His offices were at 2311 Connecticut Avenue.

Dr. Kearny was the son of Dr. Richard A. Kearny, also a physician, and Emily Ritter Kearny. He was born in Plaquemine, Louisiana, February 13, 1883. He received his early education abroad, in Belgium and England. Returning to the States, he enrolled for study at Tulane University, receiving the degree of Master of Philosophy in 1904 and his medical degree in 1905.

Following his internship he practiced medicine in Plaquemine, La., from 1906 until 1908, when he entered the United States Public Health Service. His PHS duties took him to New Orleans, Washington and other cities.

From 1919 to 1921 he was in Boston, on the resident staff of the Massachusetts Eye and Ear Infirmary; he began practicing his specialty in Washington immediately following this training.

He was a member of the senior attending staff of Garfield Memorial Hospital. In 1925 he was certified by the American Board of Otolaryngology. For some 12 years he was a special lecturer in otolaryngology at Georgetown University School of Medicine.

Dr. Kearny was an Active member of the Medical Society of the District of Columbia from 1921 until his death. He was a Fellow of the American College of Surgeons, and a member of the American Medical Association and the American Academy of Ophthalmology and Otolaryngology. He was a member of the Chevy Chase Club.

He leaves his wife, Mrs. Edmonia Adams Kearny, daughter of the late Rear Admiral J. Dexter Adams, USN; two sons, Richard A. Kearny, Jr., living at home, and Lt. James Dexter Kearny, USN, New London, Conn.; and a daughter, Miss Edmonia Kearny, who is employed by the Army in Heidelberg, Germany.

JAMES MATTHEW PHALEN, M.D., F.A.C.S.

(1872–1954)

Colonel James M. Phalen, MC, USA (retired), editor emeritus of the *Military Surgeon* since March 1954, died, October 5, 1954, at Walter Reed Army Hospital. He lived at 3000 Tilden Street, N.W. He became Secretary of the Association of Military Surgeons and editor of its official publication in 1940.

Colonel Phalen was born in Harvard, Illinois, November 26, 1872. He graduated in pharmacy from Northwestern University in 1892 and in medicine from the University of Illinois in 1900. He was an honor graduate of the Army Medical School and the London School of Tropical Medicine, and a distinguished graduate of the Army School of the Line. He was a graduate also of the General Staff School and the Army War College.

From 1907 to 1910 he was President of the Army Board for Tropical Diseases in Manila and later lecturer in tropical medicine at New York Post Graduate Medical School.

During World War I he was surgeon of the 86th Division and medical inspector for the First Army. Later he was surgeon of the Sixth Division for the Army of Occupation in Germany.

From 1922 until 1924, Colonel Phalen was Chief of the Hospital Division, Office of the Surgeon General. He was librarian of the Army Medical Library for the following three years; from 1927 to 1930 he was surgeon for the Panama Canal Department. He retired from the Army in 1936.

He was a Fellow of the American College of Surgeons and a member of the American Medical Association. He also held membership in the Military Order of Carabao and the American Legion, as well as the Army-Navy Club and the Army-Navy Country Club. He was the author of several books and articles on military history, and had contributed to the Dictionary of American Biography.

He is survived by his wife, Mrs. Gertrude Sibley Phalen.

RALPH STEVENS PENDEXTER, LL.B., M.D.

(1877–1954)

Dr. R. Stevens Pendexter, Washington ophthalmologist for 31 years, died, October 1, 1954, in Old Greenwich, Connecticut, where he had lived since 1951.

Dr. Pendexter, the son of Albion Winslow and Roxanna Stevens Pendexter, was born in South Meriden, Connecticut, November 23, 1877. He studied law at Georgetown University, receiving the degree of Bachelor of Laws in 1913, and was admitted to the District Bar. Deciding on a career in medicine instead, he studied medicine at George

CAT.

Washington University for three years, but completed his studies at Hahnemann Medical College, from which he received his degree in 1918.

He was resident surgeon at the Wills Eye Hospital in Philadelphia from 1918 to 1919. In March of the following year he began his practice of ophthalmology in the District of Columbia, with offices for many years in the Farragut Medical Building. He was on the staff of the Episcopal Eye, Ear and Throat Hospital from 1920 until he retired from practice.

Dr. Pendexter was certified by the American Board of Ophthalmology in 1924. He was a member of the American Academy of Ophthalmology and Otolaryngology, the American Medical Association, and the Hippocrates-Galen Society. He was an Active member of the District Medical Society from 1923 until 1952, when he transferred to Associate membership. He was a member of the Sons of the American Revolution, Civitan Club, Almas Temple and Albert Pike Lodge of the Masons.

Survivors include a son, R. S. Pendexter, Jr., of 9 LeJeune Court, Old Greenwich, Conn.

MAYNARD JAMES SIMMONS, M.D.

(1873–1954)

Dr. Maynard J. Simmons, retired Washington physician, and an Associate member of the District Medical Society, died, October 14, 1954, at his home, 1809 Kenyon Street, N.W.

Dr. Simmons was born in Charles County, Maryland, November 10, 1873, the son of William and Ann A. Simmons. He studied at Gonzaga College in Washington, and graduated from George Washington University School of Medicine in 1903, following which he practiced medicine in Washington. From 1910 to 1916 he practiced in Cumberland, Maryland.

Prior to World War I he went to New York for postgraduate study at the New York Post Graduate Medical School and Hospital. During 1918–19 he served overseas as Major in the Medical Corps of the U. S. Army. Upon his return, from 1921 to 1924, he was surgeon on the staff of the U. S. Public Health Service. For many years he was a United States pension examiner.

From 1925 to 1936 he owned and operated several private hospitals: Oak Lodge, in Bethesda; the Harriet Lane Sanitarium, 1654 Columbia Road, N.W.; and Pinehurst Sanitarium, Queen's Chapel Road, near Hyattsville. He retired from active practice in 1937.

Dr. Simmons was an Active member of the Medical Society of the District of Columbia from 1936 until he requested transfer to Associate status in 1940. He was a member of the American Medical Association. Other organizations with which he was affiliated were the Military Order of the World Wars, Washington Board of Trade, Knights of Columbus, and the American Legion.

His wife, Mrs. Ernestine Tegethoff Simmons, died in 1941.

THE G.P.
or
WHAT'S UP, DOC?

When you've got a pain
Or a twisted knee,
Who do you think of?—
Why of course, the G.P.
And if, to the touch
You are hot as blazes,
The room starts to spin
And your vision hazes;
There's only one person
You'd most like to see:
The comforting, competent
Friendly G.P.
You stick out your tongue
And you gurgle an "Ah";
Then clamp it down tight
On the thermometah!
He pushes the stethoscope
Round and about—
Then looks at your eyes
With a question of doubt.
"What's wrong with me, Doc?"
You ask with a shudder,
And sound like a boat
That has just lost its rudder.
"You've nothing to fear;
Get this ℞ filled;
And in two or three weeks—
You will be billed!"
If you've never been sick,
Then you don't know that feeling

Of calling a man
Dedicated to healing.
He may poke you and probe you
And seem to take glee,
That comforting, competent
Friendly G.P.
But he has your best interests
At heart, never fear,
As he sticks a steel gadget
Way down in your ear!
So if you get an ache
That's unnatural, go see
That comforting, competent
Friendly G.P.

—A PATIENT

Peptic Esophageal Inflammations—Ware

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Ephraim McDowell—Podolsky

(*Continued from page 633*)

greatest monument to Ephraim McDowell, the pioneer surgeon of the Boone Trace, who was one of the greatest masters of the healing steel.

1049 East 18th Street
Brooklyn 30, New York

MEDICAL ANNALS
of the
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VOLUME XXIII *December,* 1954 NUMBER 12

THE MENACE OF SELF-INDUCED ABORTIONS

GEORGE J. FUCHS, JR., M.D.*
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JAMES G. SITES, M.D.
Associate Medical Officer, Department of Obstetrics and Gynecology District of Columbia General Hospital

INFECTED, self-induced abortion is still one of the leading causes of maternal death. It is variously estimated that septic abortions are responsible for approximately one third of all maternal deaths in the United States. At the D. C. General Hospital, infected abortion is the single most common cause of maternal mortality. Despite antibiotics, whole blood transfusion, and other measures, these patients usually succumb to overwhelming infection. Occasionally patients succumb to renal shut-down secondary to toxic nephritis. This is usually due to the drug used as the abortifacient (mercury) or as a result of the infection.

We shall report on the nature and hazards of self-induced abortions encountered at the D. C. General Hospital. For the past 2 years the incidence of such attempted abortion has increased alarmingly. New procedures hitherto not employed are being utilized in numbers reaching major proportions. There is no doubt that the method of choice in producing self-induced abortions varies in each community and even varies from year to year in the same community. The insertion of potassium permanganate tablets into the vagina and cervix or the insertion of a male urethral catheter into the uterus are the presently popular technics utilized in this community.

POTASSIUM PERMANGANATE

Potassium permanganate can be purchased in tablet form in any drug store upon request and without a prescription. In concentrated solutions it is a strong oxidizing agent, and on contact with viable human tissue it has great corrosive property. In recent years patients have apparently been placing concentrated tablets into the vagina and/or cervix for the sole purpose of inducing abortion.

In the past 2 years 96 patients have required hospitalization at the D. C. General Hospital because of hemorrhage and burns to the vulva, vagina or cervix following the use of potassium permanganate. Many patients have been seen in the emergency rooms who did not require hospitalization. The typical pathologic lesion assumes 2 forms: (1) an ulcerated, well demarcated area usually measuring 2 to 3 cm. in diameter, the bases and edges appearing blackened and charred, and (2) a slit-like area that appears like a sharp knife wound. Because the anterior and posterior vaginal walls are directly in apposition it is the rule to find a mirror lesion on both surfaces. Varying degrees of blood loss accompany these burns, and frequent massive (over 1,000 c.c.) and sudden hemorrhage causes the patient to seek medical attention.

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* Now on duty as Captain in the Medical Corps of the United States Army Air Force.

Of the 96 patients reviewed, 12 were not pregnant, and only 2 aborted. Thus, 82 patients were pregnant with the pregnancy remaining undisturbed despite the use of permanganate. Seventy per cent of the patients were admitted to the hospital in shock or impending shock, and approximately one half of them received transfusions of from 500 to 2,500 c.c.

Other constant features were a high incidence (80 per cent) of low-grade fever, 99.6° to 101°F., and a rapid pulse rate (85 per cent) with and without a drop in blood pressure. This was interpreted as excitement and impending shock from blood loss. Several (50 per cent) had an elevated white blood cell count between 10,000 and 14,000.

The following is a typical history of a patient using potassium permanganate tablets as an abortifacient. She obtains the tablets from the "drug store" or "a friend." One to 4 tablets are inserted into the vagina. About 4 hours later the patient begins to notice a dark, bloody discharge that necessitates wearing a hygienic pad. This discharge persists for 2 to 3 hours and then is followed by massive, sudden, vaginal bleeding. At this time it is invariably the patient's understanding that she is aborting. In reality, however, the tablets have eroded and burned the vaginal tissue, and arterial bleeding is occurring.

The treatment varies, but in general the vagina and external genitalia are irrigated with aqueous zephiran. This is used to dilute the potassium permanganate and for cleansing purposes. About 60 per cent of the patients had to be anesthetized, and the bleeding vessel ligated. Occasionally a vaginal pack was employed. The follow-up treatment consisted of vaginal installation of a sulfonamide cream daily for varying lengths of time.

The sequelae of potassium permanganate burns are cicatrix, incomplete healing, and pelvic discomfort. We observed 1 patient whose lesion was still incompletely healed 6 months after the burn. In 2 cases cicatrix occurred to the degree that bands of scar tissue obstructed labor. These bands had to be incised in order to allow labor to progress. The hospital stay for this type of patient varied from 1 to 23 days, with an average stay of 4.2 days per patient.

DOUCHES

Another common method of attempting to initiate an abortion is by the use of the common douche with some chemical added. Some of the abortifacients seen in this group have been concentrated lye, strong alkaline soaps, turpentine, creosote derivatives, and mercurial compounds.

There has been 1 maternal death in the past 3 years from chemical peritonitis and toxic systemic effect, some of the material having passed through the uterus and tubes into the peritoneal cavity. In addition to the more serious complications of chemical peritonitis there may be erosion and scarring on the genitalia when the drugs are used in the concentrated forms.

When these are unsuccessful as abortifacients, the individual usually tries a foreign body.

FOREIGN BODIES

There have been 6 maternal deaths due to septic abortion at the D. C. General Hospital in the past 3 years. In addition, an average of 15 patients a month have been admitted with the diagnosis of septic abortion. A history of self-induction or other evidence such as removal of the foreign body was obtained in the 6 fatal cases and is obtained in about 90 per cent of the

(*Continued on page 712*)

THERAPY OF LATE ABORTION

L. V. DILL, M.D.

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THE recognition that spontaneous abortion is the greatest single factor in fetal wastage has led to much speculation, investigative work, and empiric therapy. The history of the "cures" for this condition reads much as a search for the philosopher's stone, and as yet we have no method by which we are certain even of reducing a portion of this fetal loss.

On the long path of trial and error in search for causative agents, certain factors stand out. The major one is that intrinsic defects in the conceptus are the fundamental cause of abortion in more than 60 per cent of cases of early abortion.[1, 2, 3] Abnormalities of the female generative tract are held responsible by some investigators in a significant although not a large percentage.[4, 5] Failures in the hormone levels required for proper endometrial growth and vascular proliferation may play a part in a small percentage of both early and late abortions.[6, 7, 8]

The nutritional aspect of abortion has been approached from several angles. Vitamin, mineral, and protein adequacy in the preconception states has been shown to protect the experimental animal against an abnormal incidence of abortion, and marked deficiencies in these elements have been able to increase this incidence. Attempts have been made to incriminate vitamin E,[9] vitamin A,[10] protein,[11] and general deficiencies in the human. Authors of individual small series claim to have demonstrated an increased incidence of fetal abnormalities and abortion in examples of malnutrition, but the over-all data obtained from Holland, Germany, and Great Britain during even serious deprivations caused by World War II show no significant increase in either phenomenon.[12, 13, 14]

It is of interest that the only large series of threatened abortions treated in this country by bed rest and sedation alone resulted in data in every way comparable to most of the series reported in which specific drugs have been credited with the increase in fetal salvage.[15] Any work which claims results, therefore, must show a statistical improvement over the results obtained by this group.

Over the last 6 years we have treated a group of individuals who have aborted normal fetuses after 16 weeks of gestation. It is felt that these patients do not fall into the general classification of habitual abortion because: (1) They aborted in the second trimester or went into premature labor early in the third trimester; (2) they almost invariably had normal fetuses; (3) labor was usually preceded by evidences of bleeding; and (4) they showed no evidence of abnormalities which would lead to a diagnosis of placenta previa, or of the precipitating factors to produce premature separation of the placenta.

Materials and Methods

Twenty-eight pregnancies in 15 patients have been included in this group. Each patient gave a history of having aborted 2 or more successive times after the beginning of the sixteenth week. All were treated by the following routine, varied only according to the time that they were first seen.

A careful history was taken in every case with emphasis on the endocrine and nutritional status. A complete physical examination was made to rule out systemic disease and abnormalities of the uterus or other pelvic organs.

Ten of these 15 patients were seen before conception had occurred, and both husband and wife were placed on high-vitamin, high-protein diets supplemented with vitamin E in daily doses of 30 mg. beginning at least 2 months before pregnancy was attempted.

Following conception these 10 patients and the 5 who sought medical advice after conception had taken place were started on the following routine: Stilbesterol according to the routine of Smith and Smith[6]; Pranone, 30 mg. daily; thyroid, 0.3 Gm. (½ grain) 3 times daily; and hesperidin, 50 mg. with ascorbic acid (Hesperidin-C*), 50 mg. daily; and restricted activity. In 4 cases restricted activity meant complete bed rest, with bathroom and dining room privileges only from 14 weeks to 36 weeks or until it was thought that the fetus was definitely viable.

When Hesperidin-C was first included as an adjunct to the therapeutic regimen, only 1 tablet daily, representing 50 mg. each of hesperidin and ascorbic acid, was prescribed. This dose in the first 4 pregnancies did not enhance the therapeutic regimen. It was suggested that we increase the daily dose to 8 to 12 tablets, representing 400 to 600 mg. each of hesperidin and ascorbic acid, and this was done in subsequent pregnancies.

RESULTS

The series includes 15 patients who have experienced 28 pregnancies under the described routine of management. Of these 15 patients, 8 had only 1 pregnancy, 4 experienced 2 pregnancies, and 1 each had 3, 4, and 5 pregnancies while under therapy.

It is of interest that the patient who had had 5 pregnancies has never been able to carry a baby for more than 28 weeks, although with each succeeding pregnancy she has added a few weeks to the gestation time. She has no living children.

The patient with 4 pregnancies had managed to have 2 living children, both in the last 2 attempts.

The patient who experienced 3 pregnancies with 2 living children went further in the term of gestation with each succeeding pregnancy.

Six of the 8 patients who experienced only 1 pregnancy under therapy managed to carry the pregnancies far enough to obtain living babies.

The results are tabulated in table 1.

TABLE 1

Analysis of Results of Pregnancies in Patients with Repeated Late Abortions—Use of Hesperidin-C Supplement

PATIENTS	PREGNANCIES EACH PATIENT	PREGNANCIES	NUMBER LIVING	PER CENT LIVING
8	1	8	6	75
4	2	8	4	50
1	3	3	2	66
1	4	4	2	50
1	5	5	0	00
Totals 15		28	14	50

COMMENT

The presumption has been made that "late aborters" have an etiology different from those who abort before 10 weeks, and it is also probable that the "late" group are heterogeneous as to cause. It is thought that some differentiation is legitimate in that the presence of primary anomalies of the fetus is unusual in the "late" group. After conception has occurred, it may be reasonable to suspect as the cause of premature labor rupture of the marginal sinus of the placenta, spontaneous onset of uterine contractions, or failure of the endocrine organs (including the placenta) or the decidua to meet the requirements of normal pregnancy.

We do not yet know how to prevent spontaneous abortions, and undoubtedly in the series described the approach has been broad. It is thought that if specific measures are of actual value, bed rest or markedly restricted activity is the most advantageous. It is not clear why the simple force of gravity may initiate or aggravate contractions; however, not only is the method of bed rest time-honored but there also seems to be real value in its studious application.

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* Hesperidin-C for use in this experiment was generously supplied by Mr. Steven Horoschak and the National Drug Company. The author is indebted for these supplies as well as for many helpful suggestions.

The utilization of a diet adequate in all respects with supplementation of vitamin C, hesperidin (vitamin P), and vitamin K, despite laboratory or clinical evidences of sufficiency, is believed to be of advantage.

The antihemorrhagic vitamins, vitamin C and hesperidin, were included in this regimen because of data published both in the experimental animal and in the human to show that deficiencies of these substances in the mother may result in decreased fetal salvage. They seemed even more indicated for this particular type of patient because the onset of labor was almost universally preceded by evidences of bright red uterine bleeding.

The use of thyroid, estrogens, and progesterone is probably of little if any value, but this series was begun in 1947 when data leaned heavily in favor of the utilization of these agents.

We cannot underestimate the necessity of avoiding an attitude of hopelessness or even *laissez faire* in this type of individual. Patients who sustain repeated spontaneous abortions either early or late in pregnancy are extremely desirous of bearing a living child and deserve only the best of medical aid as well as the most optimistic encouragement to help in the realization of their ambition. If some hope may be given that a "new medication," or increased dosage of an old one, will supply some type of magic adhesive to permit the next pregnancy to "stick," the likelihood of their attempting another pregnancy is greater than if no hope or medication is offered them.

It is unfortunate that I have utilized no control series for this study. The series was partially self-controlled, however, since these patients had successively aborted under established regimens. Further control may be used by comparison with the series reported by Colvin.[15] This group, which included 19 patients whose previous pregnancies had ended in premature labor, also eventuated in 50 per cent living babies at term. Because of the fact that over 30 per cent of these patients had had interruptions of previous pregnancies for maternal indications would lead one to believe that the group was not strictly comparable to our patients, who were medically and obstetrically within normal limits.

No statistical analysis was believed practical because of the small number of patients.

Summary

Twenty-eight pregnancies in 15 patients who have had 2 or more late abortions prior to this study are reported.

Of these 15 patients, 50 per cent of the pregnancies went to full term and resulted in normal living babies under a regimen of enforced bed rest, nutritional supplementation with hesperidin (vitamin P) plus ascorbic acid and hormonal therapy.

Some evaluation of the efficacy of the components in this therapy is attempted.

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THE DOCTOR AS MARRIAGE COUNSELOR*

WALTER R. STOKES, LL.B., M.D.
Washington

ROBERT A. HARPER, Ph.D.
Secretary, American Association of Marriage Counselors

IT IS altogether probable that most physicians of our day are spending an increasing amount of their professional time listening to the emotional woes of their patients, especially to those complaints arising out of the marital relationship. This preoccupation has always been an important part of the practice of medicine, but at least four new factors have lately given it stimulus: (1) a vast amount of popular literature on psychologic and emotional problems, through which the public has been encouraged to cast aside traditional reticence and to seek professional advice on emotional problems, (2) the creation of added life stresses by factors peculiar to our present-day culture, (3) the impact upon physicians of the newer concepts of psychosomatic illness, and (4) improving psychiatric education in medical schools and in postgraduate medical courses.

Because of the doctor's accentuated responsibility to interest himself in the emotional life of his patients it seems appropriate to examine our resources for dealing intelligently and effectively with the emotional problems that are either voluntarily laid before us or which we should strive to discover. First, however, it will be useful to survey very briefly what these are, as described by the patient.

For present purposes we shall eliminate the obviously psychotic and major neurotic disturbances. When these can be recognized in a patient he should be referred for psychiatric aid at once, since delay may be dangerous and unskilled therapy can only be disappointing. What will be considered here is a large group of complaints that are so common as generally to be regarded almost normal or as only mildly neurotic. A listing of these must include such things as inability of spouses to communicate effectively with each other; excessive sensitivity to real or imaginary injury; chronic nagging; lack of tenderness and affection; poverty of interests in common; attitudes of martyrdom about the marital relationship; severe quarrels over management of children; in-law troubles; poor management of family money; jealousy; the milder grades of both sexual impotence and frigidity; wide variance between the spouses as to frequency of sexual desire; pornographic attitudes toward sex; many lesser tendencies toward sexual deviation; extramarital love interest; and a host of psychosomatic symptoms which may be related to marital unhappiness.

It is readily apparent that complaints of the sort listed above serve to identify the existence of severe emotional stress, and all stress factors which seriously affect our patients are properly within the scope of medical concern. Any experienced psychiatrist would say of these complaints that they are mostly related to lack of emotional maturity, that they are founded in deep feelings of childish guilt, insecurity and defensiveness. This is a critically important observation to guide the clinician when he is listening to complaints of this kind. His first impulse may be to muster a wise, authoritarian attitude and exhort the patient not to magnify his troubles and to urge him to mend his errant ways. Neither of these approaches is likely to accomplish much, even if carried out in a kindly fashion, and if done in a severe manner the patient will be further upset and made antagonistic toward the doctor and perhaps toward the medical profession in general.

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* Adapted from material presented as part of a Symposium on Marriage Counseling, March 1, 1954, during the Ninth Annual Series of Intensive Postgraduate Courses of George Washington University School of Medicine.

The desirable clinical approach, always more or less well grasped by every successful clinician, consists in being a friendly and unhurried listener, intent upon two things: creating a personal relationship of genuine warmth and understanding, and carefully eliciting and appraising data related to the patient's emotional life. When sufficient data have been obtained to justify a tentative diagnosis, the clinician will ask himself two questions: Do I think it possible to help this patient through the warmth of my personal interest and understanding and through conferences with other members of his family for the purpose of bringing about improved family insights and coöperation? Or should I accept it that the patient seems to have emotional disturbances of such depth that I am not qualified to cope with them but should refer him to a qualified marriage counselor or to a psychiatrist?

In many instances even the most experienced clinician may have difficulty deciding at once which of these courses to follow. When in doubt, the first course would seem wiser. Should it prove unsuccessful, that fact in itself may cause the patient more readily to accept a referral when the need for it has become unmistakable.

The physician who undertakes to interest himself seriously in the marital problems of his patients should have certain basic equipment if he is to do well. Foremost of desirable qualifications is a sufficient degree of personal emotional maturity to be able to identify one's self with the patient's troubled feelings and to accept their importance to him. This does not mean sentimentally "taking sides" with the patient as to all of his grievances. It means simply being able to show him a genuine, dignified interest in his unhappiness and a willingness to investigate it with such thoroughness that really constructive interpretations and suggestions can be formulated. The patient should at all times have the feeling that he is a free and active participant in whatever is worked out, rather than being the passive recipient of the doctor's wisdom. When advice is given, the ability of the patient to use it will depend largely upon the kind of feeling he has toward his advisor at that point. If it is a warm, strong feeling, the advice is likely to be helpful. If it is an indifferent or hostile feeling, even the soundest of advice will have little or no therapeutic value.

Clearly it is important to consider what technics may aid in the creation of a warm personal relationship. Outstanding among these is the ability of the doctor just to be an attentive listener. Even repetitive and seemingly irrelevant talk by the patient can reveal a great deal about his personality, if one will not brush it aside as boresome, and nothing will substitute for simple listening as the basic technic for generating warm feeling toward the doctor. This the specialized counselor knows well, and his time with the patient is planned accordingly. The busy doctor in routine medical work is likely to feel so pressed for time that good listening seems impossible or merely a wished-for luxury. Yet the fact remains that successful counseling on emotional problems is seldom possible without some good, unhurried, attentive listening.

Another and perhaps equally important qualification of the successful counselor is his own personal orientation toward life. A high degree of objectivity in appraising the patient's troubles is essential. The counselor whose interpretations and judgments are strongly influenced by his own irrational biases will not be helpful. Since all of us have some irrational prejudices, the ideal of complete objectivity is never met fully, even by the best of counselors, yet it must be approximated if good therapeutic results are to be accomplished. Objectivity and emotional maturity, to which it is closely related, are powerfully influenced by the emotional experiences we have had in early family life. Some of us have been relatively fortunate in this respect, others quite unfortunate. If a would-be counselor is aware of oppressive emotional difficulties in his own life he is unwise to try to help others without first submitting himself to successful psychotherapy. It is significant that personal psychoanalysis is a firm prerequisite for all candidates seeking to enter the advanced fields of counseling and psychotherapy. Even a personal analysis cannot be viewed as wholly alleviating all personality tensions, nor can it be said to produce perfect objectivity, but it is the best means to that end which has been devised.

Familiarity with the basic literature of counseling and psychotherapy tends to promote objectivity. This means acquaintance with the kind of information to be found in the short bibliography which appears at the end of this discussion.

In respect to an understanding of the dynamics of the various types of emotional problem that have been mentioned it must be observed that the details concerning each would take far more space than is here available. However, a working familiarity with the dynamic mechanisms of emotional disturbances may be obtained through reading the books listed in the attached bibliography. Acquaintance with these very readable books will go far toward establishing awareness of the deep and unconscious roots of the commoner types of emotional disturbance. This is not meant to imply that the reader is supposed at once to become a qualified psychiatrist. On the contrary, he is likely to be made better aware of his limitations, along with getting a clearer realization of his own potential therapeutic powers. Study of these books is likely to extend the reader's ability to aid many of his patients through his own efforts and at the same time to sharpen his judgment about appropriate referral to specialists.

It is likely to be complained that the amount of reading here suggested imposes an unreasonable burden upon the already overloaded practitioner. But anyone who is really interested can find the reading time here and there, and he will be richly rewarded by the way in which he will add to his comprehension of himself and by his enhanced ability to do good diagnostic and therapeutic work when confronted by the emotional problems that are so often met in the practice of medicine.

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ENURESIS

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ENURESIS is the involuntary passage of urine by persons more than 3 years of age. The frequency of enuresis in children ranges from 8 to 26 per cent, according to various authors. Anderson[1] found 80 per cent of enuretics of nocturnal type, 11 per cent of combined nocturnal and diurnal type, 3 per cent of diurnal type, and 6 per cent associated with fecal soiling. Nocturnal enuresis usually occurs once during the night, but in a small number of instances a child may wet as often as 3 or 4 times in a night.

A considerable variety of conditions have been described as the actual, predisposing or exciting causes of enuresis. These etiologic factors are both organic and functional in nature. The possible organic causes include:

1. Irritations produced by phimosis, adherent prepuce, balanitis, vulvitis, eczema, pruritus, pinworms
2. Anatomic abnormalities—spina bifida, myelodysplasia, posterior urethral orifices, hypertrophy of the verumontanum, bladder neck hypertrophy, stricture of the urethral meatus
3. Chronic inflammation produced by cystitis, pyelitis and nephritis
4. Endocrine factors—diabetes mellitus, hyperfunction of the thyroid or adrenal gland
5. Epilepsy, idiopathic or organic
6. Allergy
7. Nutritional—thiamine deficiency and excess fluid intake
8. Hypertrophy of tonsils and adenoids
9. Hereditary—due to a single recessive gene substitution.

In spite of the many organic etiologic factors that have been proposed most series indicate that 50 to 90 per cent of cases are functional in origin, with emphasis strongly favoring 85 to 90 per cent as functional. Other factors, such as illegitimacy, prematurity, abnormally long gestation, nationality, basic intelligence, and deep sleep have been proposed but are no longer accepted.

Many psychiatrists have contributed to the study and understanding of enuresis, and they state that enuresis may be a presenting symptom of a number of different symptom-complexes. Pearson[2] has summarized these as follows:

1. Character neurosis
2. Chronic aggressive character pattern
3. Anxiety hysteria
4. Conversion hysteria
5. The result of environmental and cultural errors:
    a. Factitious enuresis—occurs in "lazy" children sleeping in a dark cold room, not readily accessible to a toilet
    b. Lack of cultural training because the parents have a lower ideal of culture than average parents, hence more likely to be environmental than hereditary
    c. Erroneous parents' ideals of the age at which a child can impose cultural restrictions on himself, the parents believing that he should be cultured before he can reasonably be expected to.

Freud was the first to state that enuresis is a masturbatory psycho-equivalent comparable to nocturnal pollution in adults. Following this, Herbert[3] described it as a phase of urethral eroticism. In a similar vein, modern psychoanalytic theories maintain that enuresis is a wishfulfilling regression to the early stages of infancy; that it serves girls as an expression of the castration complex, since urine symbolizes semen and the wetting is an outlet for the unconscious desire for masculinity. In boys it is a form of identification with the father, since it symbolizes ejaculation and thus fulfills an unconscious desire for potency. Hence it is a substitute for potency and masturbation. No conclusive evidence has been advanced to warrant the general acceptance of these explanations. Smith,[4] who is urologically oriented, states that regarding the concept of enuresis as a safety valve for children who are victims of erotic anxiety there is no reason to believe that in the great majority of these bed wetting relieves anything but bladder pressure.

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Gerard,[5] pointing out that enuresis is not a symptom with one etiology in all cases, found it to occur in a variety of emotional conflict situations. She spoke of 'regressive cases' precipitated by the arrival of a new sibling, 'revenge response cases' in retaliation for a nagging punitive attitude of the mother, and 'neurotic cases' based on unconscious fear of harm from persons of the opposite sex.

Enuresis, while most frequently seen in children, is not uncommon in adults. Most of the studies on adults are from military installations where the enuretic becomes a special problem. In civilian life the enuretic makes his adjustment through the tolerance and sufferance of his family, who often temporize with the assumption that "he'll outgrow it." In the communal military life, the enuretic cannot be given the tolerance and indulgence of his home life. He becomes a problem because of his symptom. The prevalence of adult male enuretics is estimated to be about 1 per cent. In contrast to this, Preston reported only 4 cases at the WAC camp in Des Moines out of 20,000 examinations.

A classification of enuresis and description of its psychopathology has been most clearly presented by Raines. Class I are those enuretics over the age of 3 that have not had a dry period; these are mainly children. Class II are those enuretics over the age of 3 that have had a dry period; these include children and most of the adults.

The psychologic mechanisms involved are:

1. *Hostility.* The hostility is usually toward a strict parent of the same sex. In later life, the individual's superior at work, an officer of the law, or a superior officer in the military takes the place of the strict parent. In spite of the hostile feelings, the enuretic usually stays out of trouble with the law because the hostility is mainly expressed by the enuresis and not openly.

2. *Attention-getting device.* This is demonstrated by the onset of enuresis following the arrival of a sibling, following recovery from an illness, and when a parent or superior fails to indicate that certain achievements of the individual are recognized. The desire for attention is also associated with feelings of inadequacy and fear. These may further stimulate enuresis in battle situations or bring on a relapse during a period of remission.

3. *Love.* The passage of urine through the urethra is a pleasant sensation. This urethral eroticism overflows into love in the immature personality of the developing child or the adult. Because of this sexual component, the enuretics in class I frequently become dry at puberty when other channels of love are opened.

4. Self-punishment to compensate for the feelings of hostility.

When the physician is confronted for the first time by a particular enuretic patient, the basic procedures are few. A careful history, a physical examination with special attention to the genitalia, and an intravenous pyelogram should yield sufficient information for the physician to proceed intelligently. The laboratory can help by one or two urinalyses.

The history will indicate whether the wetting has persisted as an infantile trait or began after habits of normal urinary control had been established, or whether it is a manifestation of organic urinary tract disease. The fact that in true enuresis the urine is passed in a full stream rather than by dribbling has been held by some to distinguish it from urinary disturbance consequent to obstruction or neuromuscular disease. The general condition and appearance of children with functional enuresis is usually normal, although some show varying degrees of nervousness. Excessive genital consciousness is sometimes observed in both sexes, and chronic masturbation is often reflected by prostatitis in boys and tough, leathery, labial hypertrophy in girls. A negative urinalysis and a normal intravenous pyelogram are usually found in enuretics.

Urologists stress the need for endoscopic examinations, but this procedure often 'cures' functional cases because of the unpleasantness of the procedure. These cures usually are not permanent and tend to aggravate the underlying disorder. In selected cases of organic etiology endoscopic examinations are definitely indicated.

In the voluminous reports concerning enuresis few workers have paused to consider the prophylactic aspects of this problem. Robb[6] found in all his cases some mistake or neglect in the original bladder training program of the infant. Arousing the child's antagonism to the training program must be avoided, as should emotional scenes, for these only serve to make the child the center of the stage, which will lead him to wet his bed to annoy his parents and obtain his revenge for the unpleasantness or to achieve excess solicitation. Physicians frequently fail to take time to outline a good training regimen and emphasize the importance of carrying it out completely and consistently. This is usually left for mothers to learn from various magazines and from relatives and friends.

Although there are many instances of infants being trained and with no relapses in the very early months, it seems reasonable to assume that training should not be attempted until there is sufficient maturation of structures involved to insure a reasonable prospect of success. Statistical data seem to dictate that this time should be not earlier than the eighth month of life nor later than the twelfth month. Best results will be obtained if the training is done by the one person that elicits the most favorable reactions generally in the infant. This is, of course, in most cases the mother. A chair close to the floor where the infant feels secure, in a bright cheerful spot, with a smiling and encouraging mother in attendance is of the utmost importance. Little can be gained if the child is resisting and unhappy. Many methods have been used for training, but the one most likely to succeed is for the mother to put the child on his chair at regular intervals during the day, gradually lengthening the intervals as the child learns control. Accidents are bound to happen and should be passed over lightly while much praise should accompany successful performances. Diapers should be discarded at this time, and it must be recognized that the training of boys requires more patience than does that of girls. This is due to the fact that boys require two training periods, first in the sitting position, and again in the erect position. This may in part account for the supposedly higher incidence of enuresis in boys than in girls.

Night training should not be attempted until daytime control has been obtained. When this daytime conditioned reflex has been completely established, it will tend to carry over into the subconscious mind of the child asleep. Dryness at night can be encouraged by giving milk to the child after his afternoon nap, and by giving a supper relatively low in liquids. If the child is consistently wet at night, he should be taken up before the expected time for urinating, but he should be awakened completely, not placed on his chair in a semiconscious condition. To do the latter is but to train him to urinate in his sleep. Here again the interval of time should be lengthened as rapidly as possible until it is no longer necessary to awaken him. Our goal, we must remember, is to go through the night without urinating, not merely to have a dry bed.

This may sound elementary, but it is of the utmost importance to check every detail with the mother, since this procedure requires a mother or a nurse that is completely convinced of its necessity and one who is patient and willing to follow through with the program. It is sometimes helpful to use an alarm clock to awaken the child at night. The ringing of the alarm, or rather the realization by the child that the alarm will awaken him, may speed the development of subconscious inhibitory control. If, however, with intelligent and conscientious effort on the part of the mother and the physician, full continence is not attained by the time the child is 4, one must consider the very likely possibility that an organic lesion is responsible and enlist the aid of the urologist and roentgenologist.

If there is confusion in relation to the etiology of enuresis, there is no less confusion as to its treatment. Procedures that have been advocated include: tying of the prepuce at bedtime, closure of the orifice with collodium during the night, use of a penis clamp, elevation of the foot of the bed, catheterization, bladder irrigations, paraffin injections into the bladder, distention of the bladder by hydrostatic pressure, lumbar puncture, intramuscular and epidural injections of large amounts of physiologic saline, urethral dilation, electrocoagulation of the vesical neck, presacral neurectomy, tonsillectomy and adenoidectomy, and circumcision. Various drugs have been recommended, including calcium salts, bromides, phenobarbital, phenacetin, rhus aromatica, amidopyrine, antipyrine, quinine, camphor, atropine, strychnine, scopolamine, papaverine, trasentin, ergotine, ephedrine sulfate, benzedrine sulfate, protein therapy, urotropine, and thyroid, pituitary extract and testosterone. A concentrated diet without seasoned food and low fluids is widely recommended. To complete the list, hypnotism, bitter medicine, roentgen radiation, ultraviolet radiation, hot baths, cold baths, massage, and electric current have had their advocates.

These methods of treatment have all been advanced within the last 15 years. In 1945 Alexander reported the Germans as having an electrical treatment center for bedwetters organized at Rodewisch in Saxony. This was a widely used sadistic method of treatment utilizing strong and painful galvanic current. This is not an isolated incident, and the sadism implied in the ordinary management of enuretic children is truly amazing.

The removal of punishment and disparagement does away with the most disturbing byproducts of the child's enuresis. He finds in his physician a protector and a helper. He learns that an authoritative person does not view his wetting as an expression of badness and is thus considerably relieved at least of secondary guilt feelings. The physician's encouraging demeanor increases his self-confidence and reduces his hopeless resignation. It is customary to encourage enuretic children by means of a star-chart or similar device, and to moderately restrict fluids during the late afternoon and evening. If the wetting continues in spite of the outlined regimen, then the roots of the fundamental problem lie too deeply for ordinary attitude therapy, and psychiatric assistance is needed.

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ENDOCARDIAL FIBROELASTOSIS*

Report of a Case

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A FAIRLY extensive review of the American and English literature concerning endocardial fibroelastosis did not uncover a case in which a complete study of the cardiac status including electrocardiograms, teleoroentgenograms, and fluoroscopic examinations with barium swallow was recorded and illustrated. It is therefore considered worthwhile to report the following case in which an adequate study was possible and a presumptive diagnosis established on the basis of clinical evidence and substantiated at necropsy.

REPORT OF CASE

C. C. was born at George Washington University Hospital on March 27, 1954 to a gravida III, para II mother who had a negative Wassermann test and group A, Rh positive blood. The full-term pregnancy had been complicated by a "gallbladder attack" which required hospitalization of the mother in the eighth month of gestation. Labor and delivery were normal, but the baby was cyanotic and required resuscitation. It weighed 5 pounds, 11 ounces, had a fair cry, and was placed in an incubator under oxygen.

Examination shortly after birth revealed some cyanosis and a systolic murmur over the base of the heart. A teleoroentgenogram taken the day after birth revealed an enlarged cardiac silhouette interpreted as possibly due in part to a large thymus, and roentgen therapy in the amount of 31 r was given on March 31, 1954 (figure 1). The baby was discharged as improved on April 1, 1954 and without obvious cyanosis. A repeat teleoroentgenogram on April 19, 1954 revealed no essential change in the cardiac silhouette. She fed poorly for 6 weeks and then seemed to improve but started to have brief spells of cyanosis.

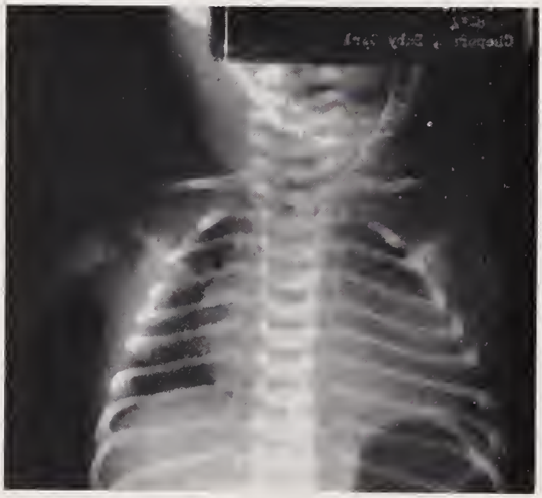

FIG. 1. Roentgenogram made the second day of life, March 28, 1954, revealing the heart to be enlarged.

When seen in consultation on June 7, 1954 the chief complaints were cyanotic spells, tachypnea, and tachycardia. Examination revealed a fairly well-developed, well-nourished, 9 weeks' old, white female infant weighing 8 pounds with a dusky color and rapid grunting respirations at the rate of 85 per minute. The lungs were clear, and the liver and spleen were both enlarged. There was sinus tachycardia with the rate of 180 per minute and a loud systolic murmur heard best along the left sternal border. No shock or thrill was palpated, and the peripheral pulses were present and equal bilaterally in the upper and lower extremities. The second pulmonic sound was not unusual. Blood pressures were unobtainable by the usual method, but the flush technic elicited a systolic pressure of approximately 40 mm. Hg in the left arm and 60 mm. Hg in the left leg.

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The electrocardiogram showed sinus tachycardia at a rate of 175 per minute, balanced axis, vertical heart, PR of 0.10 sec., QRS of 0.06 sec., and inverted T wave and depressed ST segment in V_6. It was interpreted to indicate left ventricular hypertrophy.

Fluoroscopic examination with a barium swallow in the anteroposterior view revealed the heart to be enlarged to the left, a left aortic arch, deviation of the esophagus to the right at the level of the auricles, and pulmonary vascularity within normal limits. In the right anterior oblique view both the right ventricle and left auricle were seen to be enlarged, and there were no abnormal retroesophageal vessels. In the left anterior oblique view the left ventricle was seen to be enlarged

A presumptive diagnosis of endocardial fibroelastosis was made, but other possibilities considered were an anomalous left coronary artery arising from the pulmonary artery and an aortic or subaortic stenosis. The child was digitalized and improved strikingly during the next few weeks.

On July 5, 1954, at the age of 3¼ months, the baby was admitted to Children's Hospital because of difficulty in breathing and swallowing. The general condition was surprisingly good. There was no obvious respiratory distress or cyanosis, the murmur had disappeared, and the liver and spleen were no longer enlarged. However, both the cardiac and respiratory rates were rapid, and an electrocardiogram revealed more marked evidence of left ventricular hypertrophy (figure 2). Teleoroentgenograms in the anteroposterior and both oblique views with a barium swallow confirmed the previously described fluoroscopic findings (figure 3-a, b, c). A blood count revealed mild anemia and a slight leukocytosis. A urinalysis was negative. The presumptive diagnosis remained unchanged, and the child was discharged still receiving a maintenance dose of digitalis.

On August 2, 1954, at the age of 4¼ months, the infant was brought into the emergency room at Children's Hospital dead. At necropsy the significant findings were limited to the heart. Grossly the heart was enlarged predominantly on the left, where the left ventricular wall was 1.3 cm. thick compared to a thickness of 0.4 cm. for the right ventricle. The endocardium of the left ventricle and auricle was an opaque grayish white and averaged 0.2 cm. in thickness. The endocardium of the right ventricle and auricle was slightly thickened and gray (figure 4). The foramen ovale and ductus arteriosus were obliterated, the great vessels were normally placed, and the coronary arteries were not remarkable. The valves were normal.

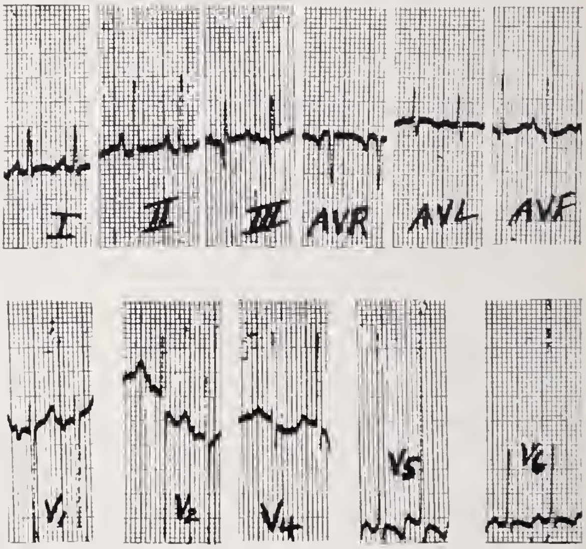

FIG. 2. Left ventricular hypertrophy (age, 3¼ months; July 5. 1954).

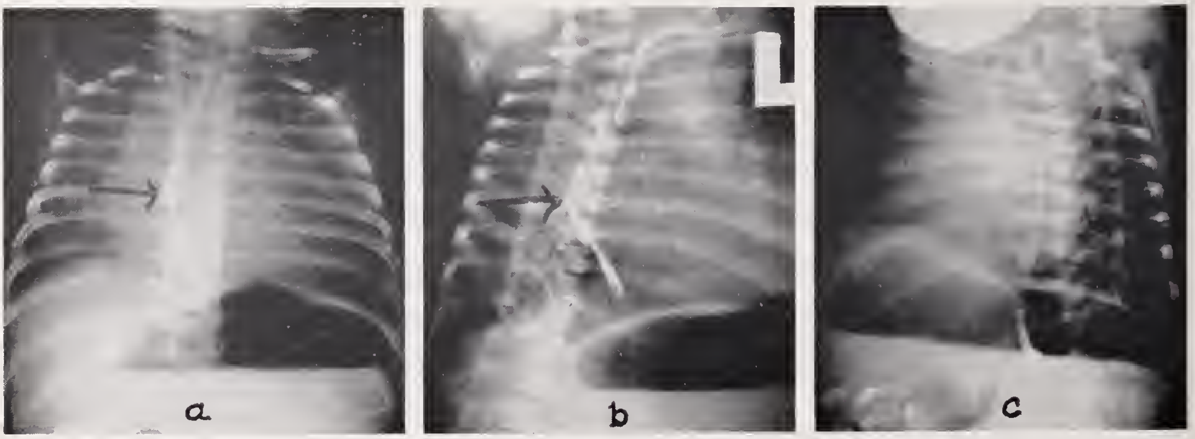

FIG. 3. a, Anteroposterior view with barium-filled esophagus; b, right anterior oblique view; c, left anterior oblique view.

Microscopic sections with special stains exhibited tremendous thickening of the endocardium of the left side of the heart composed almost completely of elastic and collagen fibers and projecting deeply into the fascicles of the myocardium (figure 5). The myocardial fibers were moderately hypertrophied, and there was no cellular infiltration.

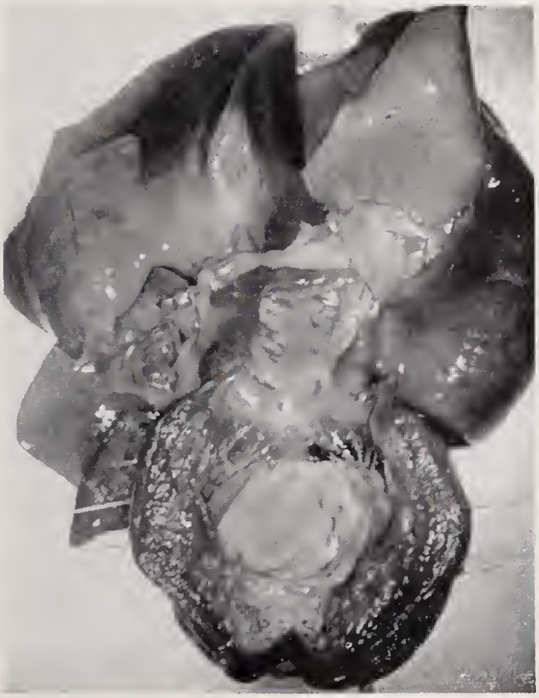

FIG. 4. Thick, white, glistening endocardium in left ventricle and auricle.

DISCUSSION

Endocardial fibroelastosis may be defined as a diffuse thickening of the endocardium of unknown etiology composed chiefly of elastic and collagen tissue and resulting in cardiac dilatation, hypertrophy, and failure.

Commonly used synonyms are endocardial fibrosis, prenatal fibroelastosis, fetal endocarditis, elastic tissue hyperplasia, and idiopathic cardiac hypertrophy.

Although the etiology is unknown, several theories have been elaborated to explain this entity, including endocarditis before or after birth, a congenital defect either as the result of a genetic factor or of a uterine environmental influence such as anoxia, degenerative changes, a metabolic disorder, or localized collagen disease. None of these theories is widely accepted.

The syndrome occurs almost exclusively in infants and children but has been described in adults up to the age of 71 years. It occurs slightly more frequently in males, and race does not seem to be a significant factor. It is a common cause of fatal heart disease in children.

The pathogenesis is not established, but the most intriguing theory is that it always develops in hearts having associated malformations which cause endocardial anoxia such as premature closure of the foramen ovale, anomalous left coronary artery, and valvular atresias.

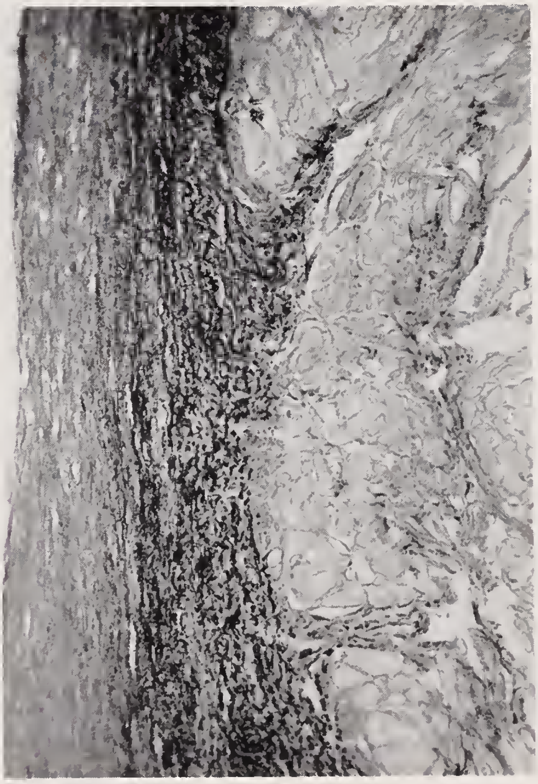

FIG. 5. Greatly thickened, fibroelastic endocardium with projections of fibrous tissue into myocardium. Reduced from a magnification of 285 times. Elastic tissue stain.

The cardinal signs and symptoms are dyspnea, tachypnea, spells of cyanosis, vomiting, anorexia, irritability, frequently a systolic murmur, marked cardiac enlargement, and predominantly left-sided cardiac failure.

The blood cell count, sedimentation rate, and urinalysis are usually normal. Occasionally there is a mild anemia, but significant leukocytosis and fever occur only as the result of coexisting infection. The serology and tuberculin skin test are negative. Teleoroentgenograms and fluoroscopic examinations with barium swallow reveal cardiac enlargement, which is predominantly left-sided. The electrocardiograms reveal evidence of an abnormal myocardium and left ventricular hypertrophy in the form of low, diphasic or inverted T waves and depressed ST segments. These changes usually occur in leads 2, 3, AVF, V_5 and V_6 although frequently the limb leads involved may be leads 1, 2, and AVL. Ordinarily the conduction is normal.

The onset of symptoms occurs before the age of 2 weeks in a third of the patients and before the age of 6 months in the remaining two thirds. Death occurs before the age of 2 years in 9 out of 10 patients and within 2 weeks of the onset of symptoms in half of the cases.

There are 3 fairly well-defined clinical types. The course is fulminating in a fourth of the cases, death occurring in minutes or hours after the sudden onset of symptoms. These infants are usually under 6 weeks of age and in good nutritional state. About one half of the patients run an acute course with the onset of symptoms occurring between 6 weeks and 6 months of age. Survival after the onset is usually less than 4 weeks, and these infants also are usually well nourished. The remaining fourth of the patients run a chronic course and are usually older infants and children and rarely even adults. The onset of symptoms may be gradual, and impaired nutrition and delayed development are characteristic. These individuals may remain in chronic low-grade heart failure despite digitalis, or more commonly may have frequent episodes of acute cardiac failure frequently precipitated by a respiratory infection or the discontinuation of digitalis therapy. They usually respond quite well to treatment of the infection and digitalis therapy.

The diagnosis can only be presumptive until confirmed by direct examination, and the differential diagnosis involves consideration of several possibilities, including an anomalous left coronary artery, aortic and subaortic stenosis, acute glomerulonephritis with cardiac failure, interstitial myocarditis, congenital malformation, and rhabdomyoma.

Some of the important articles on this subject are given in the bibliography.

Summary

A case of endocardial fibroelastosis has been described in which it was possible to perform a reasonably complete cardiac study and establish the presumptive diagnosis which was subsequently proven correct at necropsy. The salient points of the syndrome have been outlined.

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PROGRESSIVE HEREDITARY NERVE DEAFNESS[*]

Report of Four Cases in One Family

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THIS subject usually brings to mind the misnamed individual, the so-called deaf-mute, or that person who has failed to learn speech due to a severe hearing loss, usually congenital.

The group of cases presented here are not in this class. Theirs is the type of hereditary deafness that usually manifests itself between the ages of 20 and 30. It is apparent that by careful screening, such as exists in public school systems today, such cases can be picked up in fairly early childhood before the loss has exceeded the conversation level of about 30 to 40 decibels.[†]

Kenney[1] gives the following classifications of congenital deafness:

1. Hereditary
    A. True Mendelian
        (1) Dominant
        (2) Recessive
    B. Erythroblastosis fetalis
2. Malformations of external and middle ear
3. Occurrences in mother during first trimester of pregnancy
    A. Rubella or other viral disease
    B. Toxic poisoning—fume alcohol
4. Intra-uterine accidents
5. Birth injuries

It is evident that all true cases of hereditary deafness are congenital but not all congenital cases are hereditary. It is believed that this group has a dominant trait of the true Mendelian type.

The pathogenesis as reported by Albrecht[2] and agreed upon by other writers is degenerative atrophy of the spiral ganglion and cochlear nerve fibers and lack of development or atrophy of the stria vascularis of the cochlea.

Stephens and Dolowitz[3] reported on a family of 319 members, of whom 72 had the type of perceptive hearing loss that is presented here. They thought that this is a type in which the genetic factor is operative. Records kept by the Church of the Latter Day Saints were of great value in this study. The inheritance was thought to be a simple Mendelian dominant trait.

In another similar family group with nerve deafness associated with hereditary pyelonephritis the term "possible premature aging" was used.[4]

Mayo[5] advanced the following theory after making allergic tests on 535 severely deafened children. He found a 28 per cent greater incidence of allergy among them than in a normal group. Since allergies are known to have a hereditary factor, it is possible that this factor might render the fetus much more susceptible to toxemia of contagious and infectious disease.

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[*] From the Hearing and Speech Clinic of the Episcopal Eye, Ear and Throat Hospital, Washington, D. C.

[†] A bel is the increase in the intensity of a sound that is due to a tenfold increase in the energy causing that sound; 1/10 of this is a decibel, a ratio expressing intensity above threshold.

REPORT OF CASES

The family came to the attention of the Episcopal Hearing and Speech Clinic when the mother was referred by the School Health Department for an ear, nose and throat examination of a son now 11 years old. It was immediately apparent that she also had moderately severe loss of hearing. At the time they appeared in the Clinic there was realization only that the mother and the 11-year-old had hearing losses. However, on questioning it was found that 1 son and the father were the only members of the family of 8 that complained of the loudness of the radio and television.

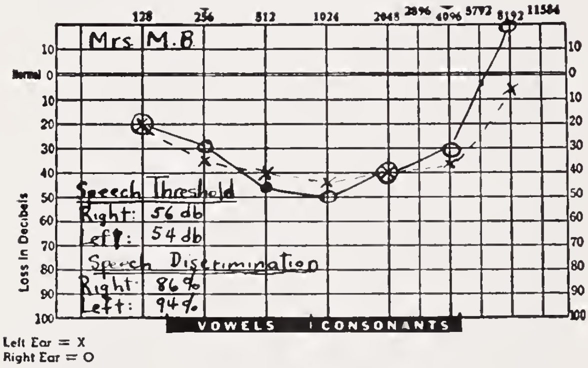

FIGURE 1. Mrs. M. B.

Initial and repeat audiograms and speech threshold and discrimination tests were made on the mother, Mrs. B., aged 29, and each of her 6 children, who at the time ranged in age from 13 to 7 years. Mrs. B. and 3 of the children, aged 11, 10 and 7, exhibit the type of deafness in question. The 3 remaining children give evidence of normal hearing but have the tendency to hear better than 0db at 8,000 cycles.* It will be noticed that the 4 members with hearing loss all indicate normal or better than normal at 8,000 cycles. Their speech discrimination scores tend to be poor, much in the pattern which is typical of moderate nerve-deafness.

An ADC, Model E-2, audiometer was used for pure tone-testing. Recordings by Telesonic Studios† of the Central Institute for the Deaf Audiotory Tests W-2 and W-22 were used to obtain speech reception thresholds and speech intelligibility scores, respectively.

Mrs. B. had had no miscarriages and no infectious or contagious disease during any pregnancy. Her Wassermann test was negative. She reported a progressive loss of hearing since about the age of 19 (figure 1). Her mother, a brother, and 1 maternal aunt, all of whom live in another, distant state, have had hearing losses since early adult life.

An earmold impression was made for Mrs. B.'s left ear. A hearing aid was recommended and obtained. The program outlined for speechreading and auditory training is being pursued at the local chapter of the American Hearing Society. The patient gives evidence of complete acceptance of her hearing aid and reports that she is now enjoying movies and radio again.

R. B., aged 11, is the second child of Mrs. B. His birth was normal after an uneventful pregnancy. His Wassermann test was negative. He has had chickenpox and measles, the latter at the age of 5, when he and his 5 siblings had the disease simultaneously. His hearing loss was noticed after he entered school (figure 2). When he was 9½ years old a series of psychologic tests was made by the Research Department of the public school system because of "retardation." His I.Q. classification placed him in the dull normal group. The Research Department recommended a hearing aid and that he be placed in a class for the hard of hearing.

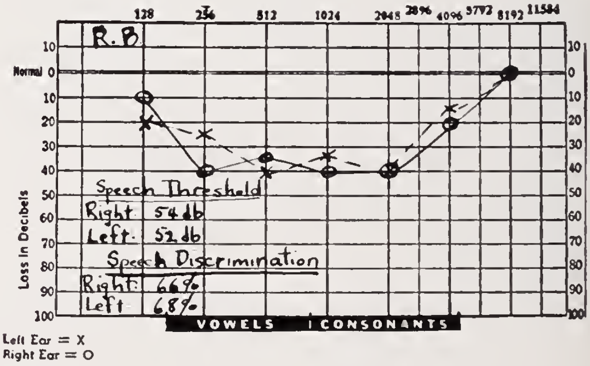

FIGURE 2. R. B.

An earmold was made for the right ear, and after evaluation procedures an air conduction hearing aid was provided. The boy is reported to have made an excellent readjustment to his regular class in school, although he continues to have difficulty in some specific studies.

Richard B., aged 10, is the third child in the family. The pregnancy was uneventful and the birth normal. The Wassermann test was negative. He had measles at 4 and chickenpox sometime later. He is a mild stutterer.

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* The number of complete cycles a vibrating molecular particle makes in one second is called frequency or pitch. This is expressed in cycles (double vibrations) per second.

† 1201 South Brentwood Boulevard, St. Louis 17, Missouri.

His work in school is rated as "fair," and his failure to do better work has been attributed to laziness. His hearing was evaluated and a loss ascertained in the hospital Hearing Clinic when the entire family was tested (figure 3).

Trial of a hearing aid has been recommended, and the boy has been referred to an agency that has funds to provide him with one. Preferential seating in school and speech reading have been advised as an interim measure.

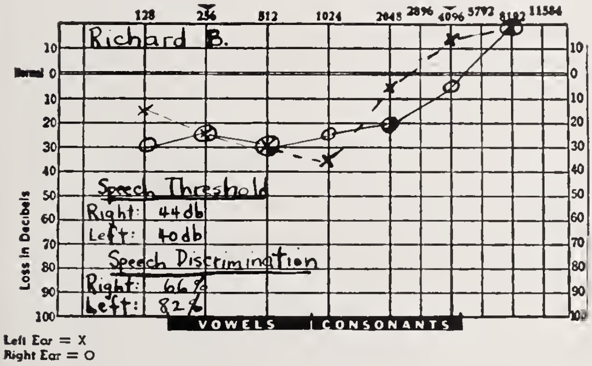

FIGURE 3. Richard B.

M. B., aged 7, is the youngest child. Her birth was normal after an uneventful pregnancy. Her Wassermann test was negative. She had measles at less than 1 year of age. The school reported that she tries very hard and succeeds and that she is rather "bossy" but she gets along well with other children. Her hearing loss was detected at the hospital Hearing Clinic when the Clinic requested that the entire family be tested (figure 4). It was thought that the results of the speech threshold and discrimination tests were unreliable, primarily because the vocabulary was far beyond the child's scope.

Recommendation was made for preferential seating in school and speech-reading instruction pending fitting of a hearing aid. She has been referred to an agency with funds for making that provision.

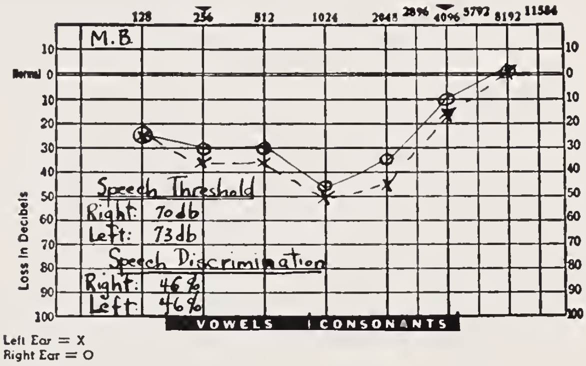

FIGURE 4. M. B.

The authors wish to thank Dr. W. H. Jenkins for his helpful advice in preparing this report.

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President's Page

THE ASSEMBLY

The Medical Society of the District of Columbia has again added prestige to its long history of accomplishments. The recent Interstate Scientific Assembly was a genuine success from every viewpoint. The scientific papers and symposia were as good or better than those heard at most national meetings. The exhibits and motion pictures depicted the newest technics and advances in medicine. Entertainment added that spice of congeniality necessary to the success of any scientific meeting. New friends were made with our neighboring colleagues.

All this was accomplished by the unselfish work of volunteer chairmen of the various committees and the loyalty of our administrative staffs. The committee chairmen and co-chairmen from Virginia had the support of their committee members and in addition volunteers from the general membership as well as from the Woman's Auxiliaries.

Those who attended the Assembly can appreciate the efficiency of its organization and those who could not be present missed much of instruction and good fellowship.

My personal thanks go to everyone concerned and the Society is indebted to them for their loyalty.

Preston A. McLendon

Editorials

PROGRESS AND THE INDEPENDENT VOLUNTARY HOSPITAL

In these days of bigger and better medical centers, often associated with medical schools, one finds new services, facilities, and technics increasingly available. We are pleased but not surprised, since the stimulus of medical teaching alone may reasonably account for them. Thus we are pleased that George Washington, Georgetown, and Freedmen's Hospitals offer a multitude of services and facilities which benefit both the patient and the physician.

However, when a small, independent hospital, having no university and no governmental affiliation, increasingly expands its services and facilities over a period of years, it is a fact worthy of special comment. The Episcopal Eye, Ear and Throat Hospital has for 50 years had the same plant and the same number of beds for patients, but during the last 25 years has greatly expanded its activities, interests, and services.

About 20 years ago this area's first "Ocular Motility Clinic" was begun under the guidance of Dr. Wm. Thornwall Davis, and with the help of the Guild of Prescription Opticians, and various service clubs, this clinic has continuously provided diagnosis and treatment for hundreds of cross-eyed children. For many years an orthoptic technician skilled in the practice of eye exercises has been in constant attendance at the hospital.

During the past number of years, a Hearing Clinic and Speech Therapy classes have been rendering rapidly expanding services. These services, given impetus by the late Dr. Leroy Sawyer and others, now employ a speech therapist and an audiologic technician in the diagnosing and treating of large numbers of children and adults.

Several years ago, through the generosity of the Variety Club, a Glaucoma Clinic was established, which has grown so rapidly and has performed so well, that a Glaucoma Review Board was formed to aid with diagnosis and to qualify treatment in the greatest of all blinding diseases. Only this month a further progressive step has been taken in establishing a Tonography Laboratory for further refinement of diagnosis of glaucoma.

Some years ago, through the efforts of Dr. Benjamin Rones, the Episcopal Hospital's interest in ophthalmic pathology was revived. Since that time monthly dinners and pathologic conferences have been held. Soon the Laboratory for Ophthalmic Pathology will open in its new quarters and offer a service which only the Armed Forces Institute of Pathology made readily available before.

All of these services and many more have been made possible by the efforts of individuals on the attending staff with the active coöperation of the Hospital Board and administration, and often with much needed assistance from foundations and service clubs. Dr. Downey has sponsored the residents' review club. Dr. Rones and, later, Dr. Stow have spent long hours planning 4 resident lectures per week in ophthalmology, given by the attending staff. These lectures are well attended by the staffs of the service hospitals as well as by the local residents.

The Tumor Board and Clinic, under Dr. Moffett, with great assistance from Dr. Klopp and others, the endoscopy service by Dr. Walker and others, the beta irradiation clinic with Dr. Caulk, the Allergy Clinic, the Anti-luetic Clinic, and a host of others, all give testimony to a staff

Opinions expressed in contributions to the Editorial Section are those of the writers and do not necessarily reflect the views of The Medical Society of the District of Columbia.

alert to the opportunity for greater service.

This is not a matter for complacency. Though the entire staff at this independent hospital is to be congratulated, the above recounting is done for one purpose only. It is to emphasize the fact that medical progress isn't necessarily dependent on having a large institution, medical school support, and Federal assistance. It may be achieved by alertness, vision, and industry by any hospital staff.

F. D. C.

PSYCHIATRY AND THE COURTS

Presumably it has not escaped the attention of members of the Society that much discussion, in the daily papers, in various public panel sessions, and on the radio, has been taking place regarding some recent decisions of the Court of Appeals for the District of Columbia regarding the defense of insanity in criminal cases. Most of the interest appears to center on the case of Durham v. United States, in which the Court adopted for the District the so-called New Hampshire Rule, enunciated by the Supreme Court of that state in 1870.

Ever since the days of Isaac Ray (whose "Medical Jurisprudence of Insanity," published in 1838, has not yet been surpassed), psychiatrists have objected to being hemmed in by artificial legal tests in testifying on the mental state of defendants. Until 1929 the only test recognized in the District was the so-called "right and wrong" test, laid down in England in M'Naghten's Case in 1843, a case involving paranoid delusions, and in a day when reason and knowledge were presumed to be the guiding forces in conduct. In 1929 the so-called "irresistible impulse" test was added, a partial recognition, at least, of the role of the will as against knowledge, but still an unsatisfactory test even in conjunction with the test of knowledge. Under these tests the psychiatrist has been compelled to answer in terms of a single symptom or two, whereas in psychiatry, as in other fields of medicine, the diagnosis is based on all the symptoms plus the history. The disapproval of the M'Naghten Rules by psychiatrists is overwhelming; one recent poll showed over 80 per cent dissatisfied, and another poll showed 90 per cent. Furthermore, the psychiatric approval of the impulse test has never been enthusiastic, the attitude being that it is only a "good start" toward making the tests more nearly in accord with modern psychiatric knowledge. Legal students as well as forensic psychiatrists have been highly critical of the Rules, and have sought for improvement.

In 1870 The Supreme Court of New Hampshire led the way in making the law responsive to psychiatric progress, and now at last, 84 years later, the District of Columbia follows its example. The doctrine laid down in the Durham Case is simple: An accused is not criminally responsible if his unlawful act was the product of mental disease or defect. The psychiatrist may now speak as a medical man to the jury, not as a lawyer or as an expert on ethics. He may explain the symptoms and history of the defendant, and it will then be left to the jury, using its good sense, to determine whether on all the facts the defendant, if he did the act, should go to the prison or to the hospital. (After all, this is pretty much the way juries work, anyway!) For there *is* provision for committing the defendant acquitted by reason of insanity, as there has been for many years in the District. The present law, however, might properly be strengthened by adopting the Massachusetts provision for an automatic life commitment in cases of acquittal, at least of homicide, by reason of insanity.

Of course, if we expect juries to be soundly guided, we should provide them with psychiatric testimony which is nonpartisan in nature. This would be a good time to consider the possibility of adopting the Massachusetts Briggs Law, which provides for an automatic reference for psychiatric examination of all defendants falling within specified legal categories. Fortunately, a start at least has been made in this direction. The new Division of Legal Psychiatric Services in the Health Department, under the direction of Dr. Thomas E. Griffin, has been established, with offices in the Court House. Under the law, the Division is available to the judges of the District Court, the Probation Offices of the District, and Municipal Courts, the Parole Board, and Department of Corrections of the District. The personnel (1 psychiatrist, 2 psychologists, and social worker at present) is inadequate in size, but it is to be hoped that, as the clinic demonstrates its unquestioned value, further funds and personnel will be provided.

The other decisions mentioned above are largely procedural, and have to do with raising the issue of insanity and with the burden of proof. They raise certain questions which will presumably become clarified as time goes on. As for the Durham Case, it may safely be expected that an epidemic of acquittals by reason of insanity will no more occur here than has been the case in New Hampshire for four-score years and more.

W. O.

CLINIC FOR MENTALLY RETARDED CHILDREN

The field of mental deficiency is characterized by an amazing variety of diverse disorders which have as a common denominator mental inadequacy. There are between one and two million mentally retarded children in this country and approximately 3,000 in the Greater Washington Area. This represents 3 per cent of the population. The exact figure is not certain because there are no inflexible standards and rules that delimit and define mental deficiency. It is quite clear, however, that, probably second only to mental illness in volume, this problem constitutes the greatest medical catastrophe that is known. In no small part, the very size of the problem has inhibited many direct, frontal research efforts to solve it. The unfortunate result is the very large group of pitiful parents who drag their unfortunate offspring from one doctor's office to another seeking some type of answer to their problem.

Local parents of these babies have banded together and associated themselves with similar groups of parents in other communities and have formed the National Association for Retarded Children. This organization, only 3 years old, has already made its influence felt in many spheres. November 14 to 21, by Presidential order, has been designated "National Retarded Children's Week," and the Association anticipates strong local and governmental support. Last year local parent groups around the country raised over a million dollars for their own projects, and this "grass roots" movement promises to gain tremendous backing at all levels. The Washington group has undertaken as their primary project the support of an evaluation clinic to be established at the Georgetown University Medical Center. This clinic will be directed by representatives from the Departments of Pediatrics, Neurology, and Psychiatry and will have an accompanying team of psychiatric social workers, clinical psychologists and secretarial help.

The immediate objective of the clinic is to diagnose and evaluate each patient, determine if possible the causes, and initiate a program of management. The treatment regimen will be based on the individual child's needs with respect to available community resources and the family's own attitude toward the problem.

Secondary objectives include the education and training of medical students, house staff, nurses, and others in this field. This training might be expected to have a broad influence in other communities when these people leave Washington to establish their own practices and accept the challenge of this problem as it exists in their own towns. A somewhat unique feature of this plan is the concept of an inpatient work-up with an integration of consultation and laboratory services concentrating on establishing an accurate diagnosis as rapidly as possible.

Another phase of the program is to provide an information center for physicians and others seeking advice on available community resources for their problem. A year ago an editorial in the MEDICAL ANNALS[1] commented on the poor liaison between the existing organizations and groups working in the general field of handicapped children and practicing physicians. The clinic should be able to offer a valuable service in this area.

Psychiatric guidance of the family unit involved should provide a tremendous help to the afflicted parents. Altogether too many parents withdraw themselves from social contacts when faced with this problem. The lack of diagnostic, institutional, and special training facilities has not provided any comfort to these families and has been the basis of frustration to their medical advisors.

Mental retardation is everyone's problem. No one is exempt from its direct contact and ten million people have had this tragedy enter their lives. Intelligence levels, race, nationality, and color are not important factors in its production and the very ambiguity surrounding the causes is a tremendous challenge.

The formation of a clinic for mentally retarded children at Georgetown University should form a rallying point for all interested in this fight and deserves the support of everyone.

F. G. B.

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[1] M. Ann. District of Columbia, 1953, 22, 673; see also 1954, 23, 157.

In and Out of Focus

BY THE OBSERVER

Interstate Assembly a Success

Not all members of our Society and of the Medical Society of Virginia were convinced that the FIRST INTERSTATE SCIENTIFIC ASSEMBLY would be a success. A few were unhappy about discontinuing their respective annual meetings, feeling that it might establish a precedent which would eventually lead to abandonment of individual meetings. There were those, too, who were pessimistic because they thought the ASSEMBLY could not be carried to its conclusion without friction between the two organizations.

Whatever misgivings were voiced in advance, they dissolved in the resounding success of the ASSEMBLY. For it was a most satisfying and, in many ways, a very stimulating event for those who participated.

Proof of this were the favorable comments voiced by District and Virginia physicians. The consensus seemed to be that the Program Committee, under its able Chairman, Dr. Theodore Winship, was deserving of the highest commendation for the spendid job it had done. The scientific program is, of course, the heart of the ASSEMBLY; unless it is sound, the meeting is a failure regardless of the "trimmings." Dr. Winship and his Committee saw to it that the best possible program was presented, and those who attended the scientific sessions were most appreciative.

What particularly pleased your Observer was the number of Virginia physicians who said they not only found the scientific program and exhibits to be tops, but they liked the friendly hospitality of Washington physicians. This was a high compliment.

As was to be expected in a joint undertaking, the meeting far outdistanced any previous ASSEMBLY sponsored by the District Society as regards size. This year there were 42 scientific exhibits as against 25 in 1953; 88 technical exhibits were on display, last year there were 49. Social gatherings were greater in number and much more ambitious than any held to date. The Annual Dinner alone was attended by a thousand physicians and their wives. They not only enjoyed the dinner but the reception which preceded it and the excellent entertainment which followed. The entertainment is reviewed elsewhere in this issue of the ANNALS (see On the Lighter Side, page 701). Much credit for the large attendance at the dinner is due the members of the Medical Society's Woman's Auxiliary, who, as always, were most coöperative.

Most gratifying was the large attendance at the dinner given for the doctors' office staffs on Wednesday evening, November 3. Some 500 secretaries, nurses, technicians, and others employed by physicians attended. The program presented by the Doctors' Orchestra was received with much enthusiasm. In response to the exhortations of Dr. Robert H. Harmon, the audience sang several familiar songs unusually well. Mr. Leo E. Brown, Director, Department of Public Relations, American Medical Association, was the speaker. His address on the role of the doctor's assistant in the AMA's PR program was well received.

One of the pleasant highlights of the ASSEMBLY was the reception given by the Women's Medical Society of the District of Columbia for visiting women physicians. Especially honored at the occasion were the women guest speakers, Dr. Susan Coons Dees, of Durham, N. C., and Drs. Grace H. Guin and Jeanne C. Bateman, able physicians of our own Society. Dr. Mary K. L. Sartwell, President of the Women Physicians of Washington, was a charming hostess.

From the beginning there was no doubt about the attendance at this ASSEMBLY. In fact, hotel reservations poured in from Virginia as soon as it became known that the meeting was to be held in Washington. More than 700 physicians, plus their wives and families, taxed the facilities of the Shoreham and Sheraton-Park Hotels to their capacity.

An analysis of the registration follows:

Members of the District Medical Society	841
Members of the Virginia Medical Society	717
Visiting physicians, Residents and Interns	472
Miscellaneous	1,098
Total	3,128

Dr. Preston A. McLendon, President of the Medical Society of the District of Columbia, and Dr. Vincent W. Archer, President of the Medical Society of Virginia, have reason to be highly pleased with the ASSEMBLY and they have so expressed themselves. Both Presidents fulfilled the responsibilities of their offices in a most creditable manner. They deserve high praise not only for their personal contributions but for the selection of an able Committee on Arrangements. Certainly no finer committee could have been assembled than that headed by Dr. Ralph M. Caulk, General Chairman of the ASSEMBLY. Fortunately, he has had much experience in planning medical conventions. In addition, he has unusual talents for organization work. Dr. Caulk was given valuable assistance by the Co-chairman of the Committee, Dr. James W. Love, of Alexandria, Virginia.

As has been stated, the scientific program was tops, largely because of the ability and thoroughness of Dr. Winship. Associated with him as Co-chairman of the Committee was Dr. Benjamin W. Rawles, Jr., of Richmond, Virginia.

Dr. Alfred A. J. Den, as Chairman of the Committee on Scientific Exhibits, revealed again his exceptional talents for his assignment. His Co-chairman was Dr. William D. Dolan, of Arlington, Virginia.

Dr. Joel B. Hoberman, Chairman of the Committee on Medical Motion Pictures, was not only tireless in his efforts to obtain the best

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THE STORY OF
Gallstones
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CAMERA HIGHLIGHTS OF THE FIRST INTERSTATE SCIENTIFIC ASSEMBLY

(1) Dr. Preston A. McLendon, President of The Medical Society of the District of Columbia, and Mr. George F. Hartford, Vice President of Station WTOP-TV who accepted the John Benjamin Nichols Award; (2) Dr. Ralph M. Caulk, General Chairman (D. C.) of the Committee on Arrangements; (3) Dr. George E. Schreiner, the Davidson Lecturer, accepting certificate from President McLendon; (4) a portion of the Technical Exhibit on display in the Main Ballroom; (5) Dr. Theodore Winship, Chairman (D. C.) of the Program Committee, conversing with Dr. Owen H. Wangensteen, of Minneapolis, Minn., one of the speakers; (6) Dr. Alfred A. J. Den, Chairman (D. C.) of the Committee on Scientific Exhibit, presenting the First Award in the Scientific Exhibit to Dr. Irvin Hantman,

(7) President Vincent W. Archer, of The Medical Society of Virginia, with President McLendon of the District Medical Society; (8) obviously enjoying themselves at the Assembly are, left to right, The Very Reverend Edward B. Bunn, S.J., President of Georgetown University; Dr. You Chan Yang, Ambassador from Korea; Dr. Raymond A. Osbourn, of Washington; and Dr. James A. Love, Co-chairman (Va.) of the Committee on Arrangements.

(9) Seated around the table in the Palladian Room at the Annual Dinner, November 2, were (center front left and counterclockwise): Dr. Walter B. Martin, President of the American Medical Association, President McLendon, Dr. W. Ross Morris, President-elect of the District Medical Society, Mrs. Martin, President Archer, Mrs. McLendon, Dr. Carrington Williams, Sr., who was installed earlier that day as President of the Medical Society of Virginia, Mrs. Archer, Dr. John

(*Continued on page 691*)

medical motion picture programs but showed rare perception in his selection of films. Dr. W. E. Baker, of Alexandria, was Co-chairman of Dr. Hoberman's Committee.

Dr. Josephine Renshaw, Chairman of the Committee on Publicity, and Dr. Milton R. Stein, of Arlington, Co-chairman, as was expected, did a very competent job. They were ably assisted in radio and television presentations by Mr. Lou Brott, of Washington.

Dr. Richard H. Todd, Chairman of the Committee on Social Events, and his Co-chairman, Dr. John C. Watson, of Alexandria, and their Committee, are deserving of the numerous kudos which they received for a fine dinner and the very enjoyable program which followed. As stated previously, the entertainment is "written up" elsewhere in the ANNALS.

The Committee had labored long and diligently in staging the revue entitled "Skitsophrenia"—A Medical Mélange. The cast—all doctors and their wives—had the advantage of professional direction by Mr. Joseph I. Judge, of Washington.

Special mention should be made of the Doctors' Orchestra, which was one of the hits of the evening. The ensemble's efforts were received with unrestrained enthusiasm. The director of the Orchestra, and an able one, was Dr. Isadore M. Alpher.

Dr. Robert U. Cooper, Chairman of the Finance Committee, and his Co-chairman, Dr. Jerome N. Baum, of Alexandria, plus their Committee, were charged with the responsibility of seeing to it that the solvency of the ASSEMBLY was not threatened.

For the first time there was a joint administrative staff, on which there were employees of both medical societies. They were both diligent and coöperative and everything ran more smoothly than could have been anticipated.

This year's ASSEMBLY will stand out for years to come as a happy and historic event. It is to be hoped that not too many years will pass before a similar meeting can be arranged.

Now we press on to the ANNUAL SCIENTIFIC ASSEMBLY's Silver Anniversary, which will be held next October.

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Awards Conferred

An increasingly important feature of the District Medical Society's ANNUAL SCIENTIFIC ASSEMBLY is the presentation of awards. This year they were augmented by those presented by the Medical Society of Virginia.

All present at the Tuesday morning session of the FIRST INTERSTATE SCIENTIFIC ASSEMBLY, held in the Terrace Banquet Room at the Shoreham, will recall that it was jam-packed with interested spectators who greeted the recipients of awards with much applause.

Awards presented by Dr. Preston A. McLendon, President of the Medical Society of the District of Columbia, were as follows:

Certificates for Meritorious Service: Dr. Daniel L. Borden and Dr. James A. Gannon were this year's recipients.

Dr. Borden, well known surgeon and former President of the District Medical Society, was given his Certificate because his "career has been characterized by outstanding accomplishments, unswerving integrity, and deep loyalty to his profession, his alma mater, his community, and his country which he served with distinction in three wars. As President during a critical period in the history of the Medical Society, he gave steady guidance, inspiring much needed confidence. His wise leadership will always be held in grateful remembrance."

Dr. Gannon, also a well known surgeon and former Chairman of the Society's Executive Committee, was honored "for his outstanding services to the medical profession and to the people of the District of Columbia. The Medical Society is especially proud of his successful efforts to raise the standards of medical care in the

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(*Continued from page 690*)

RICHARD MORRIS, JR., of Charlottesville, Va., and MRS. WILLIAMS; (10) DR. JAMES A. GANNON, accepting the Certificate for Meritorious Service from PRESIDENT McLENDON; (11) DR. DANIEL L. BORDEN, accepting the Certificate for Meritorious Service from PRESIDENT McLENDON; (12) partial view of The Story of Gallstones, a scientific exhibit from the Guthrie Clinic, Sayre, Pa., presented by special invitation.

District's public institutions, and to improve Washington's public school system. Both physicians and laymen in the Nation's Capital are deeply indebted to this courageous and high-minded physician."

Davidson Lecture Award: The recipient of this award was Dr. George E. Schreiner, Director of the Renal Service, Georgetown University School of Medicine, for his paper on "The Physiology of Arteriovenous Fistulas." He was presented with a certificate and an honorarium.

The Davidson Lecture was established May 1, 1929, as an enduring expression of the gratitude of the Medical Society of the District of Columbia to Edward Young Davidson, M.D., who, when President of the Society in 1916, conceived and led to completion the Society's building at 1718 M Street, N. W., Washington, D. C.

John Benjamin Nichols Award: This year's choice was Station WTOP-TV in recognition of its pioneer efforts in health telecasts.

This award was established in memory of one of Washington's most eminent physicians, the late Dr. John Benjamin Nichols, for the purpose of recognizing the lay person or lay organization, or both, nominated by the Society's Committee on Public Information, and approved by the Executive Board, for outstanding contributions to the health of the community. Three 13-weeks series of programs were presented by Station WTOP-TV in 1953 in coöperation with the District of Columbia Health Department and with the assistance of a number of local community organizations. Titles of the series were: "Alcoholism, the Road Back"; "Very Dangerous," which was devoted to the efforts to eradicate venereal disease; and "Face to Face," which dealt with emotional disturbances and their treatment. This award is in the form of a certificate and a medal. Present to receive the award for Station WTOP-TV was its Vice President, Mr. George F. Hartford.

The 1953 award was presented to the Variety Club of Washington, D. C.

Dr. Alfred A. J. Den, Chairman of the Committee on Scientific Exhibits, presented awards in the form of certificates to the following scientific exhibitors:

First Award: Dr. Irvin Hantman, for his exhibit, "Diseases of the Ear Drum, New Technics of Teaching Ear Diseases, Presentation of Ear Manikin."

Second Award: Dr. James M. Moss, "The Symptoms of Diabetes Mellitus."

Third Award: Drs. Charles E. Rath and Douglas W. Terry, "Homozygous Hemoglobin C: A New Hereditary Hemolytic Syndrome."

Certificates of Merit: Drs. Garnet W. Ault, Robert S. Smith, and Alejandro F. Castro, for their exhibit, "Extended Resection for Cancer—Distal Colon and Rectum"; Dr. Eugene Lowenberg, "Peripheral Vascular Diseases, Arterial, Venous and Lymphatic"; and Drs. Lewis H. Bosher, Jr., Alfred M. Decker, Jr., and Jaquelin M. Harrison, "Esophageal Reconstruction by Esophagojejunostomy and Esophagocologastrostomy."

Dr. Vincent W. Archer, President of the Medical Society of Virginia, presented the following awards for his organization:

Membership in the 50-Year Club: The award, in the form of a certificate, is given "in recognition of fifty years of devoted service to the public in the practice of medicine." The following 17 members of the Society received the certificates: Drs. Paul Anderson, Elisha Barksdale, Charles Singleton Dodd, William Thomas Dodd, John Milton Gouldin, Ernest L. Grubbs, George Wesley Hooker, Hatley Norton Mason, Edward Howe Miller, William McMath Revercomb, Stuart Wray Selden, William Almon Shepherd, Thomas Watkins, William C. Webb, John Mason Williams, George A. Wright, and Edward Franklin Younger.

A Special Award to the Physician in Virginia Who Had Done the Most for the Physically Handicapped: The recipient of this award, which was in the form of a certificate, was Dr. Roy M. Hoover, orthopedic surgeon, of Roanoke, Virginia.

The ceremonies concluded with the installation of Dr. Carrington Williams, Sr., of Richmond, as President of the Medical Society of Virginia, to succeed Dr. Archer.

Footnotes in Medical History—I

Two occurrences in early October, seemingly totally unrelated, stirred memories of nearly forgotten incidents and prompted these observations.

The first was the death on October 7 of one of the country's outstanding medical leaders, Dr. James C. Sargent of Milwaukee, Wisconsin, Chairman of the AMA's Council on National Defense. Dr. Sargent was perhaps best known to the physicians specializing in urology, a field in which he gained wide recognition. However, his activities in organized medicine, beginning with the presidency of the Medical Society of Milwaukee County, spanned some twenty-five years. During this period he rose steadily to national eminence, becoming successively President of the State Medical Society of Wisconsin, delegate from his state to the AMA's House of Delegates, where he served a number of years, and, finally, chairman of one of the AMA's most important councils. He served with distinction in World War II as Captain in the Navy's Medical Corps.

These, then, are some of the salient facts about Dr. Sargent's career. Admittedly impressive, they would not, in your Observer's opinion, be complete without the inclusion of his significant contribution to the medical prepayment movement in the early 1930's.

Herein lay the link to another occurrence in mid-October which revived the recollections related here. This was the appearance in pamphlet form of "The Story of Blue Shield" by Robert M. Cunningham, Jr. in which, among other things, the history of nonprofit medical prepayment plans is reviewed. Mr. Cunningham states that the first plan to be established was the California Physicians' Service, which began operation in 1939. A year later the Michigan State Medical Society got under way with the Michigan Medical Service. The 1940's saw a rapid increase in the number of plans and an astonishing growth in the enrollment of subscribers. It was in this period that the Blue Shield organization came into existence.

Understandably, no mention is made of the activities in Milwaukee on behalf of the medical prepayment movement several years before these plans came into existence. The purpose of these comments is to give proper recognition to Dr. Sargent, who was the community's most ardent advocate of the prepayment principle at a time when urging its adoption was courting the enmity of fellow physicians. In fact, Dr. Sargent was roundly criticized by many men who were otherwise friendly to him for what they considered his "crack-pot" ideas.

Twenty-five years ago your Observer was a neophyte in medical organization work, having just been employed by the Medical Society of Milwaukee County. He was learning what his assignment was all about when the findings of the Committee on the Costs of Medical Care, of which the late Dr. Ray Lyman Wilbur was chairman, first made their appearance in medical journals and the lay press.

It was in 1931 that he first discussed with Dr. Sargent, then incoming President of the Milwaukee Society, some of the Committee's findings. He expressed the opinion that the prepayment principle was certain to gain in public favor and that in a very few years it would be an accepted method of paying medical bills. Why not be in the vanguard of such a movement? Dr. Sargent said he would think it over. A short time later he announced his intention to devote his term of office to establishing the first medical society-sponsored prepayment plan in the country.

Dr. Sargent was not a man to do things by halves. When he accepted responsibility, his enthusiasm for the business at hand was boundless. Furthermore, he was a man of unusual energy which, too, seemed limitless. As he himself admitted, these were both virtues and faults and at times he welcomed the brakes being applied. At any rate, once committed to the establishment of what later became known as the Milwaukee Plan, he devoted nearly all his time outside his practice to the project. Day and night he and his associates hammered away at the Plan. There was no precedent to follow, only meager actuarial figures were available, and there was no individual experienced in a comparable field to turn to. This did not deter Dr. Sargent, whose mind was in a ferment.

It soon became evident that opposition was shaping up within the profession. The crusade, as some labeled it, was too advanced in its basic philosophy to be acceptable, Dr. Sargent was warned. Efforts were made by some of his friends to dissuade him from presenting the Plan to the Society until a more propitious time, but he would not agree to a delay.

It is interesting to note that the Plan developed largely by Dr. Sargent is one that has been gaining favor in recent years. Basically, it was simple enough. Every individual coming into the Plan would be required to pay 5 per cent of his income directly for needed hospital and medical services before he became eligible for benefits. He was then protected up to certain prescribed limits. There was no limitation placed on income of participants. Because of the deductible feature "premiums" were low. Physicians were to be paid in accordance with a fee schedule approved by them.

Support for the Plan came from various sources. A welcome surprise was the approval of the late Dr. R. G. Leland, Director of the AMA's Bureau of Medical Economics. However, his ardor was soon dampened by his superiors. Those who espoused a compulsory health insurance program were of course vocal in their insistence that the Plan be given a trial. At least, they said, this would be a beginning.

Medical leaders were for the most part passively opposed. The late Dr. Olin West, then Secretary of the American Medical Association, made no bones of the fact that he considered voluntary health insurance the inevitable forerunner of compulsory insurance. Officials of the state medical society were unusually silent as consideration of the proposed plan by the Milwaukee Society approached. Privately, local physicians did not question Dr. Sargent's sincerity, but they were not so complimentary with respect to his judgment. Such adjectives as flighty, unpredictable, and impetuous were frequently bandied about.

On the evening that Dr. Sargent unveiled the Plan to the Society, little opposition was voiced. In fact, it might have been better if there had been. An obvious lack of enthusiasm put a damper on the proceedings. The meeting had hardly begun before a motion was adopted referring the Plan back for further study to the special committee which Dr. Sargent had appointed to aid with its development.

The outcome should not have been as disappointing to Dr. Sargent as it was. He was much let down at the time but in a few days his optimistic nature again took over. That was one of his most attractive qualities. There were few peaks and valleys in his emotional make-up. It was finally agreed that education of the profession was needed if it was to be won over to Dr. Sargent's program.

A series of conferences devoted to a discussion of the economic problems of medicine and voluntary health insurance were arranged for the following summer, to which all members of the Society were invited. These attracted only a moderate number of physicians but those who came became deeply engrossed in the subject discussed and later some became leaders in the prepayment movement.

It was during the period immediately preceding the meeting of the Society at which the Plan was shelved that Dr. Sargent was invited to Chicago to meet with a special committee of the AMA headed by an eminent physician long since deceased. The committee had been created because AMA officials were troubled by the activity in Milwaukee and wished to discuss the matter with Dr. Sargent. Upon his return he announced with much enthusiasm that the Plan had been approved by the committee and he had been assured that a statement would be issued by the chairman to that effect. When the statement was received Dr. Sargent reported with chagrin it contained no reference to the Plan—that it was merely a restatement of medical ethics as they relate to prepayment medical plans. However, Dr. Sargent's disappointment was short-lived because soon thereafter he was informed that the essentials of the Plan had been incorporated in the first minority report of the Committee on the Costs of Medical Care as the type of plan which the medical profession favored.

This, then, is the story of Dr. Sargent's efforts to convince his fellows that the time was propitious for organized medicine to lead the way in the medical prepayment movement. Time has confirmed the fact that he was right. However, fate decreed that he would have to be content to write a footnote in medical history.

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Have We Lost Something?

As informed doctors have long recognized, the basic issue in the controversy over medical care is the ability of the average citizen to meet the costs of illness. Solve this problem to the satisfaction of the people and the medical profession and the troubles besetting physicians of this country would vanish; that is, most of them would.

The way things stand now, the public appears to be under the impression that, where medical costs are concerned, physicians are figuratively sitting on their hands. This is unfortunate in the light of the remarkable progress of nonprofit medical prepayment plans. Admittedly, these plans still have a long way to go to meet the needs and demands of the people. But this cannot be accomplished overnight. Patience on the public's part is as essential as diligence is on the part of the medical profession.

Considering the large amount of money expended annually by the physician-sponsored Blue Shield Plans for the purpose of keeping the public fully informed of their progress, one would expect commendation rather than criticism. But many people, or at least the most vocal of them, are evidently not convinced that the profession is putting forth an honest effort to do something about burdensome medical costs.

Many reasons can be advanced for this situation. One is that organized medicine has taken an unpopular position with respect to a number of other issues. Opposition to medical care for veterans with nonservice-connected disabilities at Government expense, to certain types of lay-controlled medical prepayment plans, and to the Administration-favored health legislation certainly has evoked hostility in many quarters. But these differences should not obscure accomplishments to the medical profession's credit.

In reflecting on these and related matters, your Observer has come to the conclusion that what is missing in organized medicine's public relations programs is emphasis on the ideals to which the majority of physicians adhere.

Not long ago a medical man addressed an audience of physicians' aides. It was an excellent and practical talk in which sound advice was given. It struck your Observer at the time, however, that one thing was missing—there was nothing that would suggest that medicine is a high calling and not a "trade"; that practical economics, as important as they are, are decidedly secondary in the practice of medicine; that a physician worthy of the name is a dedicated individual.

He could not escape the further conclusion that if the medical profession is to counter the onslaughts of its critics successfully, the public must somehow be convinced that these are not merely high-sounding platitudes but truths.

Obviously, words are not enough. The real need, as your Observer sees it, is to fortify the physician-patient relationship by warmth, understanding, and mutual trust. In the final analysis, this is the key to public confidence.

"I Had a Case . . ."

Most doctors' views about other physicians are so familiar as to be commonplace. It seems that everything that can be said has been said time and again and that, in this respect, at least, there is nothing new under the sun.

A recent incident, however, contained a surprise element and it would appear that there really is something new. It occurred during the First Interstate Scientific Assembly and, at the time, provoked considerable amusement among those present.

The physician responsible for the incident, who will not be named, said that he never invited doctors to his home because, to him, they were boring company. "How come?" he was asked. "Because," he replied, "they always talk shop and apparently can't dismiss medicine from their minds even in social gatherings. Whenever two or more doctors get together, one or the other inevitably starts the ball rolling by saying, 'I had a case. . . ,' and then he is off on a long discussion of the patient's peculiarities, difficulties encountered in diagnosis and treatment, laboratory findings, prognosis, and so on ad infinitum."

The doctor said he could not take shoptalk after a hard day's work—that others might listen but that he couldn't and wouldn't. "Why can't doctors relax like other people," someone asked him. The doctor said frankly he did not know unless it is because medicine is too hard a taskmaster, leaving little time for anything else. Whatever the reason, he had found a solution which satisfied him.

Most physicians would undoubtedly take issue with this doctor, pointing out to him that in few professions is there more fraternization than among physicians; that physicians find real and rewarding satisfaction in each other's company; and that the majority are glad to forget medicine when the opportunity offers.

This would not budge this doctor. Experience has taught him otherwise. Let others listen to fellow practitioners who liven up a party with "I had a case. . . ." He has had enough.

T. W.

CALENDAR OF SPEAKERS

The following members of the Medical Society of the District of Columbia have addressed lay groups during the past several weeks. The Society maintains a Speakers Bureau, sponsored by the Committee on Public Information, through which requests for speakers for lay groups, including radio programs, can be filled.

Date	*Speaker*	*Subject or Title*	*Organization*
October 5	Dr. John R. Pate	Tuberculosis in 1904 and 1954	Washington Civitan Club
October 13	Dr. I. Phillips Frohman	Tuberculosis, Lung Cancer, and Heart Disease	Health Forum, Young Men's Christian Association
October 13	Dr. Louis Goldstein	The Anatomy, the Physiology and the Hygiene of the Female	Student Group at University of Maryland, College Park
October 13	Dr. Frederick C. Heath	Public Health Activities in District of Columbia	Zonta Club of Washington
October 13	Dr. Christopher J. Murphy, Jr.	Functions, Aims and Activities of the Alexandria Medical Society	Alexandria Chapter, American Cancer Society
October 26	Dr. Winfred Overholser Dr. David W. Harris	Comeback—rehabilitation of a mentally ill person	WTOP-TV

SPECIAL REPORT OF THE EXECUTIVE BOARD*

When you were notified of this meeting, matters to be dealt with by the Board were specified. These are the subject of this report. With the notice sent you was a pamphlet entitled "An Important Message to Members of the Medical Society of the District of Columbia," which it is hoped you have read as the information it contains will be the principal item of business.

Major General Dan C. Ogle Proposed for Honorary Membership: On July 14, 1954, General Ogle succeeded Major General Harry G. Armstrong as Surgeon General of the United States Air Force. While deep regret was expressed at the departure of General Armstrong all recognized the unusual ability of his successor.

General Ogle was graduated from the University of Illinois College of Medicine in 1929 and from the School of Aviation Medicine at Brooks Field, Texas in 1931. He is also a graduate of the Medical Field Service School at Carlisle Barracks, Penna., and the Air War College (1949).

In 1942 General Ogle was named post surgeon of the Technical Training Center, and the following year assumed command of the Army Air Force Regional Station Hospital, Coral Gables, Fla. In 1944 he went overseas as staff surgeon of the 15th Air Force in Italy, and in 1949 became Deputy Surgeon General of the Air Force. Later he was transferred from the Army to the Air Force. In March 1953 he was named Surgeon for the United States Air Forces in Europe.

The Board is pleased to propose General Ogle for Honorary membership. As required by the Society's Constitution and By-laws, this proposal will be forwarded to the Board of Censors for its approval and presented for a vote of the Society at its next business meeting.

Election of Dr. Joel T. Boone to Honorary Membership: Dr. Boone was proposed for Honorary membership at the Annual Business Meeting of the Society on May 5, 1954 and passed by the Board of Censors on August 20, 1954. As pointed out to the Society, Dr. Boone is Chief Medical Director of the Veterans Administration and one of the country's most distinguished physicians.

He served with distinction in both World Wars I and II. In World War I he was battalion and regimental surgeon for the 6th Marine Regiment, later being Assistant Division Surgeon of the Second Army Division, AEF. For extraordinary heroism he was awarded the Medal of Honor by Congress. In World War II he was Fleet Medical Officer on the staff of Admiral W. F. Halsey. Dr. Boone retired as a Vice Admiral on December 1, 1950 after spending 36 years in the Navy.

Among other assignments during his long career have been the following: Director of Naval Affairs for the American Red Cross; physician to Presidents Harding and Coolidge and personal physician to President Hoover. In addition he served in 1946–47 as Medical Advisor to the Federal Coal Mine Administration and as Director of Medical Survey of the Coal Industry.

The Board is pleased to recommend Dr. Boone's election to Honorary membership.

Proposed Amendment XXV Providing for Change of Committee Designation. At its meeting on October 1 the Committee on Industrial Medicine voted to recommend to the Society that the name be changed from Committee on Industrial Medicine to Committee on Industrial Health. It was the consensus of the Committee that in view of the limited industrial activity in the District of Columbia the recommended change of the Committee's name would be more appropriate. The Amendment reads as follows:

AMENDMENT XXV

Article I and Article VII of Chapter VIII of the Constitution and By-laws are hereby amended by changing the name of the *Committee on Industrial Medicine* to the *Committee on Industrial Health.*

This Amendment will be voted on at the next business meeting.

Adoption of Amendment XXIV Providing for Increase in Membership Dues. In the introduction to this special report hope was expressed that all members, especially those present here tonight, had had an opportunity to examine the pamphlet sent them last week setting forth the accomplishments of the Society in the past decade; the chart showing the Society's income, operating expenses, and capital expenditures at 5-year intervals for the period of 1943–1953; and reasons why an increase in dues at this time was being sought.

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* Adopted at a special Business Meeting of The Medical Society of the District of Columbia, November 10, 1954.

To refresh your memories as to the contents of the pamphlet, each of you has been provided a copy together with a copy of this report. While the content of the pamphlet speaks for itself the Board would like to comment on some of the facts mentioned.

Under the caption "A Decade of Progress" there appears in the center spread inside the folder comparisons which speak eloquently of the astonishing growth of our Society. It will be noted, for example, that membership in all classifications has increased from 1,160 to 1,964, or 69.3 per cent.

Immediately below the membership figures is shown the number who comprised the office staff in 1943 (5), and in 1953 (9). Properly this item should have followed "Activities" because the membership factor alone is not a criterion on which to base the personnel required to carry out the Society's program. Quite the contrary, although keeping the membership records requires more than twice the time it did in 1948.

Responsible to a considerable degree for this was the decision of the American Medical Association's House of Delegates at its meeting in Washington in 1949 to require members of the Association to pay dues, and that these dues should be collected by state medical societies to be transmitted to the AMA. This placed a heavy burden upon the limited staffs of many state medical societies, including our own.

There is no need to review the growth of the Society's activities in more detail than is shown in the pamphlet. It is set forth briefly and graphically and can be taken in at a glance. However, the Board wishes to call attention to items that have the most direct bearing on the proposal under consideration.

For instance, the ANNUAL SCIENTIFIC ASSEMBLY has expanded more rapidly than any other activity of the Society. Whereas preparation for the ASSEMBLY could at one time be deferred until the last few weeks before the meeting, it now requires many months of effort in which all of the office personnel participate. To put it another way, the demands now made upon the Society's office staff in connection with the ASSEMBLY are far greater in proportion than they were back in 1943.

Medical Bureau is usually thought of by those informed about the Society's affairs as a separate unit having its own staff, which, of course, it does. Nevertheless, the Bureau cannot divorce itself from the Society, and it receives the attention and assistance of the office staff not directly connected with it.

Perhaps the greatest increase in activity has been in relation to personal services, i.e., responding to countless telephone calls regarding physicians' training and scholastic background, complaints, requests for information about medical meetings, out-of-town hospitals, and a variety of other factual data relating to medicine. In addition, the Secretary deals with an ever increasing number of calls from physicians for advice in a variety of matters.

Just a brief comment on the items listed under "Projects Approved but Dormant." Some of these might not be deemed by you as essential, but included in the list are projects which in the past have been approved by the Society and for lack of personnel have been temporarily abandoned.

The fact of the matter is that for many years the office staff found it possible to cope with a number of these projects, but as certain activities rapidly expanded this was found impossible. At present the staff is putting forth the maximum effort but is unable to keep up with more than the bare day-to-day work incident to membership, committee meetings and programs, and other administrative work resulting from the activities of a large and progressive state society.

It should not be necessary to emphasize the importance of cash reserves commensurate with the size of the Society's operations and the extent of its real estate holdings. As pointed out in the pamphlet, the building in which we are now meeting was built in 1920. It is therefore 34 years old. While it was originally constructed of the finest material with superb workmanship throughout, it is showing the wear and tear of time. In recent years there have been an increasing number of replacements and repairs.

The building at 1710 M Street, N.W., which adjoins the one in which we are meeting, is much older and not nearly so well constructed. For many years it was an apartment house. Approximately $22,000 has been spent on the first floor over a period of some 15 years to make it suitable for offices. These are now used by the Society and the Medical Bureau. The upper floors, still used as apartments, are in passable condition. The plumbing is long since obsolete. It would appear to be only a matter of a few years until this building will have to be restored or replaced.

Obviously a building fund should be set up and a stipulated amount of the income set aside for this purpose each year. Within 10 years there should be a sufficient sum available to make a building program not too burdensome for the membership.

You may be interested in the fact that the Society's accumulated cash reserves from all sources not earmarked for any specific purpose now amount to $54,836. Considering the size of the Society's operations, the cash reserves might well be twice this amount to insure the stability of the Society's finances and its capacity to meet any demands which might be made upon it.

The bar chart which appears on the left hand inside page of the pamphlet is self-explanatory. It reveals that the Society's experience is similar to that of other organizations since the recent War. While there has been remarkable growth, inflationary conditions have had their effect.

Although the inflationary processes have been somewhat slowed up, they have not come to a halt. This was forcibly brought home recently when the printers of the MEDICAL ANNALS notified the Society that, as of the first of the year, the printing cost would increase 12 per cent.

Another situation with which the Society must cope is the proposal to increase the compensation of Government employees by 5 per cent. Legislation incorporating a wage increase in this amount was passed in the last Congress but was vetoed by the President, who has given his assurance that another bill will be introduced which he will sign. If such legislation is enacted prompt consideration will have to be given the compensation of the Society's employees.

Dr. Herbert P. Ramsey, a member of the Executive Board, will discuss the financial picture in somewhat more detail immediately following this report. Dr. Ramsey is thoroughly familiar with the Society's financial situation and will clarify points which have only been touched upon in this report.

It is hoped that if Amendment XXIV is adopted there will be sufficient funds to absorb the increase in operating costs and permit the employment of at least 2 additional individuals in the Society's office, a secretary and a clerk-typist. This will relieve the executive personnel of many routine details for more vital duties relating to carrying out the Society's policies.

In conclusion, then, the adoption of Amendment XXIV would make it possible to absorb increased costs, the employment of essential office personnel, and the establishment of a building fund in which a definite sum would be put aside annually from the Society's income. Considering the size of the proposed increase in dues, the amount of this sum would of necessity be modest.

The proposed Amendment XXIV reads:

AMENDMENT XXIV

Section 1. Amendment XX of the Constitution and By-laws is hereby repealed.

Section 2. Effective January 1, 1955, Active members shall pay fifty dollars per year in dues, except that recent graduates who have been in the active practice of medicine for less than three years shall pay for their first year fifteen dollars, for their second year twenty-five dollars, and thereafter fifty dollars. Members, at their option, may pay such dues in two equal installments, the first installment being due and payable January 1st of each year and the second installment being due and payable the succeeding June 1st.

Respectfully submitted,
WALLACE M. YATER, M.D., *Chairman*
KARL C. CORLEY, M.D.
HUGH H. HUSSEY, M.D.
PRESTON A. MCLENDON, M.D.
WILLIAM ROSS MORRIS, M.D.
HERBERT P. RAMSEY, M.D.
R. LOMAX WELLS, M.D.
THEODORE WIPRUD, *Secretary*

PROGRAM
THE MEDICAL SOCIETY OF THE
DISTRICT OF COLUMBIA
1718 M Street, N.W.

January 12, 1955, 8:15 p. m.

PANEL DISCUSSION ON
COMPETITIVE ATHLETICS

GEORGE MAKSIM, M.D., *Moderator*
Member, Committee on School Health, American Academy of Pediatrics, and liaison representative from the A.A.P. to the National Education Association

Panel participants to be announced.

Physicians' wives are cordially invited to attend this meeting.

GRIEVANCE COMMITTEE CASE REPORTS

The following report is based on a complaint received recently by the Grievance Committee. While all the facts presented are true, they have been arranged in such a manner as not to embarrass anyone. The sole purpose of this report is to call to the attention of members of the Society, in as graphic a manner as possible, typical complaints with which the Committee must deal. The Committee hopes that they will serve to promote a better understanding of the problems which arise between physicians and patients and how best to solve them, thus building up a better relationship between members of the medical profession and their patients.

Case Report 3

Mrs. C, a Government worker, was knocked down by an automobile and sustained a laceration of the scalp, contusions, and a slight concussion. As she lay in the street, stunned but not unconscious, her head bleeding, Dr. X came along in his car and offered his services, which were accepted. With the help of a policeman she was placed in the doctor's car and taken to a hospital.

The lacerated scalp required 8 sutures and was sutured by Dr. X. He also had various X-ray and other examinations made, and entered her in the hospital. He said he considered her condition "very serious" and he remained at the hospital with her for several hours. She said her condition was "never critical." Thereafter he visited her in the hospital once or twice daily and on the sixth day, as she complained of pain in her hip, an X-ray examination was made. This showed a simple, incomplete fracture of the great trochanter. An orthopedist was called. He advised rest in bed for 2 weeks longer. He did not see her again.

Several days before leaving the hospital Mrs. C asked Dr. X when she might return to work. He told her that she could return whenever she wished but advised her to remain at home 2 weeks after leaving the hospital and to come to his office daily for diathermy. She left the hospital on the nineteenth day following the accident and returned home. Thereafter, for the next 2 weeks she visited his office and was given diathermy fairly regularly, but not daily, and was then discharged.

Shortly thereafter she received a bill from Dr. X for $342 for his services. She considered this excessive and protested. She said he told her the insurance company would not object to his bill and would pay it in full as rendered. She replied that the amount of his bill would be deducted from the amount of damages to be paid her, so that it would all eventually come out of her pocket.

According to her, he then agreed to accept $300; he says $275. She then appealed to the Grievance Committee.

The Committee encountered many delays in getting the information it needed and in effecting settlement. The case dragged on for months. In the end, the Chairman of the Grievance Committee wrote Dr. X: "It is the opinion of the Committee that the frequency of visits in the hospital as well as the total amount of the postoperative care seem out of proportion to the diagnoses available: (1) lacerated scalp, and (2) incomplete fracture of the great trochanter."

The Committee suggested that a charge of $35 instead of $70 be made to cover the services rendered the night of the accident, that one visit a day in the hospital (at $4 a visit) would have been entirely sufficient for a patient not acutely ill, and that even if daily visits were necessary in the office for diathermy, a charge of $5 a visit would be more appropriate. The Committee considered his bill for $342 excessive and recommended that it be reduced to one half that amount, and that he write Mrs. C to that effect.

Dr. X, after some time and some prodding by the Committee, wrote Mrs. C that he wasn't interested in the money to be paid him for his services and to send whatever fee she considered due him from her to the hospital nursing school, as the school needed money and that he would be satisfied. Dr. X sent a copy of this letter to the Committee.

The Chairman then wrote Dr. X that Mrs. C should not be made to feel that she was an object of charity and to send his bill to Mrs. C for the amount suggested by the Committee, and that when paid it would then be his personal privilege to send it to the nursing school or do what he pleased with it.

Ten days later the doctor replied that Mrs. C had already sent $75 to the hospital and that if she was satisfied, he would consider the case closed.

On the Lighter Side

Dr. Clyde P. Reeves, bowling member of the Columbia Hospital team of the D. C. Medical Bowling League, had for himself a big night in bowling last month and won the top prize in the Second Annual Duckpin Operators Association tournament.

Dr. Reeves

Dr. Reeves rolled the best set of his career in the finals with a 151–128–113–392 set. This combined with a 93-pin handicap gave him a gross of 485 for top prize of $150 in the men's division.

Out of 215 bowlers who finished in the money, 2 other physicians, Dr. L. S. Berman and Dr. Andrew J. Betz, won $10 and $3 respectively.

Dr. Reeves won his prize the spectacular way. In the first game he had a 64 in the sixth frame when Lady Luck embraced him in the seventh and he rolled a spare. A solid strike, another strike, and a final spare gave him a whopping big 151, which was enough to help him win over the second place prize winner by a scant 9 pins.

Dr. Reeves, "The Champ," as he is affectionately known to the other members of the Columbia team, has been hard put since then to live up to his press notices.

BROADWAY TAKE NOTICE: The histrionics of the medical profession in Washington and nearby Virginia heretofore have been limited strictly to the class room or to the conference room. Now it can be told that we have actors and actresses within our midst who can be pretty darned good when the occasion demands.

"'Skitsophrenia'—A Medical Mélange" played to a capacity house recently and just about made the Annual Dinner of the FIRST INTERSTATE SCIENTIFIC ASSEMBLY the tremendous success that it was. This mélange, put on by a heterogeneous group of doctors and doctors' wives, was produced and directed by Mr. Joseph I. Judge, Jr., with the suave and urbane Dr. Richard H. Todd as the master of ceremonies. The Doctors' Chorus, with the talented Dr. Earle Thompson as director, was in fine voice and harmony. The Doctors' Orchestra, under the able baton of Dr. Isadore M. Alpher, played prettily and in tune. Responsible for the incidental music played between numbers and accompanist for all the songs was Dr. Maurice van Kinsbergen, whose nimble fingers on the piano helped shorten the waiting period between sketches.

The members of the orchestra were as follows: piano—Drs. George Cardany, Jr. and Seymour Itscoitz; violin—Drs. Samuel Dessoff, Daniel Yuter and W. Montague Cobb; cello—Drs. Frederic C. Chapman and Oliver E. Thompson; bass—Dr. George D. Selby; saxophone—Drs. Robert C. Hill, T. Tayloe Perry, and Forrest Swisher; trumpet—Dr. George W. Sprehn; trombone—Dr. James M. Moss; clarinet—Dr. Thomas M. Leonard; drums—Dr. Aris Carpousis; flute—Dr. Christine W. Kehne; and harpists—Mrs. Ruth Thompson and Miss Thora Thompson.

The warblers in the Choral Group were Drs. William B. Clotworthy, Jr., Harry S. Douglas, Frank M. Hand, Irma Hobart, Hugh O. House, Richard V. Mattingly, Millard F. Ottman, Jed W. Pearson, Jr., Thomas M. Wilson, and Mrs. Harry S. Douglas, Mrs. C. K. Fraser, Mrs. Vasilios Lam-

First Appearance of the Doctors' Orchestra at Annual Dinner bros, Mrs. Earle Thompson, Miss Ardith Trimmer, and Miss Helen Houseman.

The cast of characters in the sketches was as follows: Mrs. Vasilios Lambros, Miss Nancy Burdick, and Drs. Harry S. Douglas, Hugh O. House, William B. Clotworthy, Jr., Earle B. Thompson, Allan M. McKilvie, Charles W. Jones, Thomas G. Edison, I. Phillips Frohman, Colin McRae, Clifford Webb, Gordon Daisley, James Gordon, John A. Kneipp, Samuel Zola, Allen M. Ferry, Leonard Dub, and Mary K. L. Sartwell. Not the least notable were television artist Chumley, a St. Bernard guest, from Adele's Pet Shop, and Vonny, immaculate French poodle of Mrs. Edward Farrell, R.N., who played their roles to the hilt.

The costumes for the skits were provided by Mrs. Edward C. Wilson, Jr., and all the rehearsals were performed in the hall of the Petworth Methodist Church.

From the Mailbag: Aside to Dr. B. L. Hardin, Jr.: Sorry. We were caught with our descriptive noun down.

From on the Lighter Side to all good sports and sportsmen—A Merry Christmas and A Very Prosperous New Year.

J. Earl Kadan, M.D.

WOMAN'S AUXILIARY NOTES

The Woman's Auxiliary to the Medical Society of the District of Columbia took quite an active part in the recent First Interstate Scientific Assembly, which we thought one of the most successful ever held here. Beginning with a coffee hour on Monday, November 1, at the Sheraton-Park Hotel, the Auxiliary warmly welcomed the wives of the visiting Virginia physicians. On Tuesday they were entertained at a luncheon and fashion show, while their husbands read papers and examined exhibits. Tuesday night was the highlight of the three-day convention. The cocktail party which preceded the dinner was jam-packed—and the dinner was well attended—(also very good)—but the entertainment—excellent! It was very gay and amusing and all who worked so long and diligently must feel well rewarded at the success of their efforts. We are eagerly looking forward to a return engagement.

On Wednesday, November 10, the Woman's Auxiliary will have as guest speaker, Mrs. Arthur F. Stricker, to demonstrate holiday table decorations and flower arrangements.

Mrs. Albert E. Marland
Publicity Chairman

MEMBERSHIP

The following applicants for membership will be voted on at the meeting of the Executive Board, January 24, 1955.

For Active Membership

Clarence E. Bunge, Indiana University—1938
C. Richard A. Gilbert, University of Virginia—1944
Wilder P. Montgomery, University of Chicago—1935
John E. Smith, University of Vermont—1937
Francis L. Wenger, Georgetown University—1947

For Associate Membership

Neville K. Connolly, Harvard University—1944
Josephine G. Kety, Women's Medical College of Pennsylvania—1941
Elliot Migdal, Chicago Medical School—1949
Bertram C. Snyder, Georgetown University—1949
Francis J. Troendle, Georgetown University—1948

For Resident-Intern Membership

William F. Schmidt, George Washington University—1951

Recent changes in membership status:

Active to Associate
J. Thomas Schnebly
Joseph W. Still

Resigned
Active
Tiffany Lawyer, Jr.

Resigned
Associate
Thomas Arnet
Arthur Bergman
J. Robert Teabeaut

News and Personals

MEETINGS

The 19th Annual Convention of the National Gastroenterological Association and the First Annual Convention of the American College of Gastroenterology were held as a joint meeting at the Shoreham Hotel, October 25–27.

A Panel Discussion on Twenty-five Years' Observation of the Gallbladder Controversy was moderated by Dr. Roy Lyman Sexton, of Washington. Two of the participants in the panel were also members of the D. C. Medical Society: Dr. J. Burton Glenn, who spoke on "Our Most Serious Differential Diagnosis, the Coronary Heart and Gallbladder Disease," and Dr. Harry Lee Claud, who presented a paper on "Surgical Approach to the Problems of Gallbladder Disease."

Dr. Henry A. Monat organized a Panel Discussion on Amebiasis, presented on October 25. He discussed "Some Problems in Amebiasis as Viewed by the Practitioner" and introduced the moderator, Dr. Norman B. McCullough of Bethesda, Md.

On October 26 a Symposium on Esophageal Varices was moderated by Dr. Irving B. Brick. Participants were Lt. Colonel Eddy D. Palmer, MC, USA, Dr. Charles A. Hufnagel, and Major Edward J. Jahnke, MC, USA, all of Washington. Dr. Hufnagel, an Active member of the District Medical Society, spoke on "Surgical Treatment of Portal Hypertension."

Dr. William T. Gibb presented a paper on "Gastric Decompensation." "Cancer of the Distal Colon and Rectum—Treatment by Extended Resection" was a joint contribution by Drs. Garnet W. Ault, Robert S. Smith, and Alejandro F. Castro.

Several members of the District Medical Society also took part as instructors in the Course in Postgraduate Gastroenterology, October 28–30, which followed the scientific sessions. Subjects presented and instructors were: "Hiatal Hernia," Dr. Brian Blades; "Oral Lesions of Gastroenterologic Interest," Dr. Raymond A. Osbourn; "Unusual Problems in Biliary Tract Surgery," Dr. Robert J. Coffey; and "Rectal Problems," Dr. Walter H. Gerwig, Jr. Dr. Irving B. Brick participated in a Panel Discussion on the Management of Gastric Ulcer.

The scientific sessions of the **48th Annual Meeting of the Southern Medical Association,** held in St. Louis, Mo., November 8–11, 1954, were well seasoned with Washington talent. Following is a list of papers presented at various sectional meetings under the authorship of D. C. Medical Society members:

Section on Medicine: "Macroglossia: A Diagnostic Clue of Systemic Disease," Dr. Harold J. Jeghers; "Results of Anticoagulant Therapy by a Simple Bedside Blood Prothrombin Test," Dr. Benjamin Manchester; and "Use of Nitrogen Mustard in the Treatment of Lymphoblastomata," Dr. Charles E. Rath

Dr. Oscar B. Hunter, Jr. opened the discussion of Dr. Manchester's paper. Dr. Rath's presentation was part of a Panel Discussion on Diseases of Lymph Nodes: Therapeutic Problems before a joint session with the Section on Pathology.

Section on Gastroenterology: "Diagnosis and Management of Esophageal Varices," Dr. Irving B. Brick

Section on Pathology: "Neoplastic Lesions in Lymph Nodes," Dr. Henry Rappaport. Dr. Rappaport is presently in Chicago but retains his Associate membership with the Medical Society.

Section on Radiology: "Diagnostic Radiology in Gynecology and Obstetrics," Dr. Fred O. Coe

Section on Allergy: "Quinoline Therapy of Asthma," Dr. Charles F. Geschickter

Section on Physical Medicine and Rehabilitation: "Accruing Advantages of Modern Planning in Physical Medicine and Rehabilitation," Dr. A. B. C. Knudson

Section on Orthopedic and Traumatic Surgery: "Whiplash Injuries," Dr. Eugene G. Lipow

Section on Gynecology: "Radical Surgery, Electively, and After Radiation Therapy in the Treatment of Cervix Cancer," Dr. J. Keith Cromer

Section on Obstetrics: "Transverse Presentations," Drs. Robert H. Barter, Louis J. Maciulla, and Peter Soyster

Section on Urology: "Metabolic Aspects of Resistance and

Inflammation as Related to Urological Surgical Management," Dr. William P. Herbst

Section on Public Health: "The Medical and Preventive Aspects of Juvenile Delinquency," Dr. Daniel L. Seckinger.

Dr. Manchester and Dr. Knudson also participated in the Scientific Exhibit. Dr. Manchester demonstrated "A Simple Blood Prothrombin Test for the Control of Dicumarol Therapy" in the exhibits in Medicine, with an accompanying moving picture film. Dr. Knudson's "Evaluating the Patient's Abilities" was among the exhibits relating to Physical Medicine and Rehabilitation.

Dr. Barter, who is Associate Professor of Obstetrics and Gynecology at George Washington University School of Medicine, was elected Secretary of the Section on Gynecology.

The 55th Annual Meeting of the American Therapeutic Society preceded the meetings of the Southern Medical Association in St. Louis and was held at the Chase Hotel, November 4–7. Dr. J. Winthrop Peabody, Sr. presented a paper, prepared jointly with Dr. J. Winthrop Peabody, Jr., on "Present-day Methods in the Management of Pulmonary Tuberculosis."

Dr. Frank W. Konzelmann took part in a Symposium on Electrolyte Disturbances. The title of his paper was "Sodium—Its Normal Physiology, Alterations in Disease and Therapy of Abnormal States."

Among the organizations which met conjointly with the Southern Medical Association in St. Louis was the **Southern Society of Cancer Cytology.** Dr. Lois I. Platt, of Washington, was program chairman for this meeting and presided at the opening session, November 8. Dr. Platt also presented a paper at the meeting, November 9, on "Usefulness of Best's Carmine Stain in Routine Cytologic Technics."

Dr. Cecile L. Fusfeld, also from the District Medical Society, presented a paper on "Vaginal Cytodiagnosis in a General Practitioner's Office" at the morning session, November 9. Presiding at this session was Dr. Robert W. Barter, of George Washington University School of Medicine.

The Section on Neurology and Psychiatry of the Medical Society of the District of Columbia and the Philadelphia Neurological Society held a joint meeting at the College of Physicians of Philadelphia, November 5.

Four scientific papers were presented by Philadelphia physicians during the afternoon session. The papers were discussed by Drs. Francis M. Forster, Clarence S. Greene, James P. Murphy, and Harold Stevens, of Washington.

The Section on Anesthesiology met, November 29, in the Medical Society's Library to hear Dr. Kenneth K. Keown, Professor of Anesthesiology, Hahnemann Medical College, Philadelphia, speak on "Anesthesia for Intracardiac Surgery."

Dr. I. Phillips Frohman, Chairman of the Section on General Practice of the District Medical Society, presented a paper before the **George Washington University Medical Society,** November 17. "Are Medical Meetings Necessary? Are There too Many Medical Meetings?" was the interesting topic he discussed.

The Jacobi Medical Society held its second fall meeting on November 15 at the Washington Hotel. Following dinner, a panel discussion on "Direct Intracardiac Surgery under General Hypothermia" was presented by the following speakers: Dr. Edgar W. Davis, cardiac surgeon; Dr. Charles E. Fierst, anesthesiologist; Dr. Bernard Walsh, cardiologist; and Dr. John Nestor, cardiologist.

The fall **Metropolitan Washington Tuberculosis Conference,** November 17, was an all-day meeting. Dr. Hugh H. Hussey, Professor of Preventive Medicine, Georgetown University School of Medicine, and Dr. Sol Katz, Chief, Department of Pulmonary Diseases, D. C. General Hospital, led a sectional meeting on Medical Education.

Dr. Ralph G. Beachley, President of the Conference, presided at the opening general session and at the general meeting in the afternoon. Dr. Roy G. Klepser was elected President, succeeding Dr. Beachley. Dr. Katz was named Vice President.

Dr. Howard M. Payne, Professor of Medicine, Howard University School of Medicine, received a citation for outstanding services in the field of employment of the physically handicapped from the President's Committee on Employment of the Physically Handicapped; the certificate was presented by District Commissioner Renah F. Camalier.

Dr. Donald R. Sickler, Chief, Tuberculosis Control, D. C. Government Health Department, took part in a panel discussion on "Looking Ahead" which was moderated by Mr. Edward K. Funkhouser, Executive Secretary of the D. C. Tuberculosis Association.

Some 300 physicians, nurses, and others engaged in the tuberculosis work of the District of Columbia, Maryland, and Virginia attended the conference in the Department of Health, Education and Welfare auditorium.

The Ninth Annual Meeting of the District of Columbia Division of the American Cancer Society was held in the Washington Gas Light Company auditorium, October 14. Elected President for a second term was Mr. Frederick P. H. Siddons, Vice President of the American Security and Trust Company. Dr. C. Roger Kurtz was among the new members elected to the Board of Trustees.

The Baltimore-Washington Dermatological Society elected new officers at its meeting, October 21, at the George Washington University Hospital. They are:

Dr. Jack L. Derzavis, *President;* Dr. Albert Shapiro, Baltimore, *Vice President;* and Dr. R. C. V. Robinson, Baltimore, *Secretary-Treasurer.*

GENERAL NEWS

At the meeting of the **Executive Board of the Medical Society of the District of Columbia,** October 25, the Secretary reported that **Dr. Lee McCarthy** had presented an X-ray picture to the Society which had been taken in 1896, probably the first X-ray picture of a human subject in the District of Columbia. The patient, whose hand was X-rayed to locate a bullet, was Mr. Carl Loeffler, aged 81 years, retired Secretary of the Senate, who came to the Society's offices upon request to be interviewed and photographed. At that time Mr. Loeffler showed the Secretary another X-ray film taken recently showing that the bullet which appeared in the original X-ray had not been removed. The Board requested the Secretary to express its gratitude to Dr. McCarthy for this historic picture. Both pictures are being framed and will be placed in the cabinet in the Society's library.

The Washington Heart Association announces that applications should be sent in immediately for research fellowships and grants for the fiscal year 1955–56.

Fellowships in Clinical Cardiology (postdoctoral) are open to graduates of approved medical schools for training in the cardiovascular field. The stipend of $3,600 per annum is awarded for periods of 1 or 2 years.

Research Grants-in-aid are made to nonprofit institutions in direct support of a particular investigator, for a specific program of research under his direction. Grants are awarded in support of research in the cardiovascular field or basic sciences related to it in amounts up to $5,000 per annum for periods of one or more years.

The original deadline for receipt of applications, December 15, has been extended to January 15. Application forms may be secured from the Executive Director of the Washington Heart Association, 1154 19th Street, N.W., Washington 6, D. C. Dr. John M. Evans is Chairman of the Research Committee of the Heart Association.

George Washington and Georgetown University Schools of Medicine have recently established chapters of the national medical honor society, **Alpha Omega Alpha,** in their respective schools.

At ceremonies at the Army-Navy Club, October 15, 22 charter members were initiated into the George Washington Chapter. They included 5 faculty members, 9 students, and 8 members of the June 1954 graduating class. Faculty members were Dr. Walter A. Bloedorn, Dean of the School of Medicine, and Drs. Thomas McP. Brown, Preston A. McLendon, Winfred Overholser, and John L. Parks. Dr. Leland W. Parr and Dr. Joseph H. Roe were named honorary members.

The charter for the newly organized Chapter of the Society was presented by its national President, Dr. Walter L. Bierring, of Des Moines, Iowa. According to the Society's constitution, membership is vested in "medical men and women who as undergraduates have given promise of becoming leaders in their profession or who later have attained such leadership." Dr. James J. Waring, Professor of Medicine Emeritus, University of Colorado, was the principal speaker; his subject, "The Gentle Physician." Dr. Waring's grandfather, Dr. James J. Waring, was Dean of George Washington University School of Medicine in the 1860's.

Thirty Georgetown University physicians and medical students were initiated into the Chapter at a formal dinner in Maguire Hall on the University campus, October 16. The Very Reverend Edward B. Bunn, S.J., President of the University, received the charter from Dr. Bierring, the Society's President. Acceptances were made on behalf of the faculty and students, respectively, by Dr. Francis M. Forster, Dean of the School of Medicine, and Charles E. Edwards, Class of 1955. Dr. Howard T. Karsner, Medical Research Advisor to the Surgeon General of the Navy, addressed the gathering.

Of the 30 initiates, there were 7 faculty members, 13 members of the Class of 1954, and 10 members of the Class of 1955. The faculty members were Dean Forster and Drs. Robert J. Coffey, Harold Jeghers, Andrew A. Marchetti, Mario Mollari, Othmar C. Solnitzky, and Theodore Koppanyi.

The Joseph Stiles Wall Auditorium at Children's Hospital was dedicated in brief but solemn ceremonies, November 18. As the program progressed, the warm personality of the great pediatrician for whom it is named seemed to permeate the new auditorium.

Dr. Malcolm Marshall, Rector of St. Margaret's Episcopal Church, gave the invocation. Judge Edgar Murdock, President of the Board of Directors of Children's Hospital, related how Dr. Wall had approached him regarding the necessity for a meeting place for the medical staff, and how gradually those hopes materialized until finally a place for an auditorium with a seating capacity of 180 was made in the plans of the new Hospital.

Dr. Edgar P. Copeland, Chief of the Medical Staff Emeritus, accepted the auditorium in the name of the Hospital. The auditorium, he remarked feelingly, "will be more or less hallowed ground for the generation who knew him and who worked with him for so many years."

Dr. Harry Bakwin, President-elect of the American Academy of Pediatrics, and Professor of Clinical Pediatrics at New York University-Bellevue Medical Center, mentioned a few highlights in Dr. Wall's long medical career. Dr. Wall was one of the founders of the Academy, which came into existence in 1931; he received in 1946 the only citation given by its Executive Board for services above and beyond what is expected of a physician in the line of duty. Dr. Wall was President of the Academy in 1945–46.

Dr. Wallace M. Yater, Past President of the Medical Society of the District of Columbia, described Dr. Wall as one of the great men in medicine. As Professor of Pediatrics at Georgetown University School of Medicine, where he served on the faculty for 47 years, he was a wonderful lecturer—lucid, interesting, entertaining. For his role in the enactment of the law regulating the Healing Arts Practice Act in the District of Columbia, the District Medical Society presented him with a scroll in 1929. In 1948 he was awarded the Society's Certificate for Meritorious Service. In 1951 a portrait was made of Dr. Wall, and it hangs in the Society's Board Room.

After benediction was pronounced by the Reverend Thomas O'Donnell, Regent of Georgetown University School of Medicine, the guests present for the occasion, among them many colleagues and friends of the late Dr. Wall, partook of a buffet luncheon.

Among those who arranged the program were Drs. Copeland, Preston A. McLendon, and William F. Burdick, all of the medical staff, and Miss Edith A. Torkington, Administrator, of the Hospital. Among the distinguished guests present for the occasion was Dr. Edward Y. Davidson, dean of the D. C. Medical Society.

Georgetown University School of Medicine has received two new research grants from the Public Health Service, totaling $48,505. One grant, in the amount of $36,000, will enable Dr. Francis M. Forster, Dean of the Medical School and Professor of Neurology, to evaluate new anticonvulsant drugs. Dr. Joseph F. Fazekas, Chief of Staff, D. C. General Hospital, and Clinical Adjunct Professor of Medicine at Georgetown, was given $12,505 for research in cerebral circulation and metabolism.

Dr. Russell M. Wilder, former Professor and Head of the Department of Medicine at the Mayo Clinic, was presented the AMA's Joseph Goldberger Award in clinical nutrition in Washington, D. C., November 5.

The gold medal award and a check for $1,000 were presented to Dr. Wilder at the Annual Meeting of the Food and Nutrition Board of the National Research Council by Dr. Grace Goldsmith, New Orleans, a member of the AMA's Council on Foods and Nutrition.

Dr. Wilder was among the early and important contributors in the field of nutrition. He perhaps is best known for his studies of diabetes mellitus, carbohydrate metabolism, and a program for vitamin-enriched bread flour. He participated in the organization of the Food and Nutrition Board of the National Research Council in 1940 and was its first chairman; he remained a member of the Board until 1950. He also was a member of the AMA's Council on Foods and Nutrition from 1933 through 1951.

While in Bethesda, Md., as Director of the National Institute of Arthritis and Metabolic Diseases, Dr. Wilder was affiliated with the District Medical Society as an Associate member.

Parke, Davis & Company has for 26 years carried on its own "See Your Doctor" campaign. The November issue of the MEDICAL ANNALS contained one of the messages in this series under the caption, "When Parke-Davis speaks to the public."

Each message in the series emphasizes the same major theme: the importance of prompt and proper medical care. The "See Your Doctor" messages have appeared and are currently published in the *Saturday Evening Post*, *Life*, *Time*, *Newsweek*, *Today's Health*, and other leading magazines. Parke, Davis & Company, long an advertiser in the MEDICAL ANNALS, is to be commended for these pertinent messages.

PERSONALS

Dr. Charles A. Hufnagel, Director of Experimental Surgery at Georgetown University School of Medicine, was awarded the 1954 Distinguished Service Medal of the Cosmopolitan Club at a special luncheon in the Mayflower Hotel, October 28. Dr. Hufnagel, the first physician to be so recognized by the Club, was chosen in recognition of his work in cardiac surgery; he performed the first insertion of a plastic valve heart, and was the first surgeon to substitute animal arteries for diseased human arteries in living persons. Dr. John F. Keaveny, Chairman of the Awards Committee, presented the medal to Dr. Hufnagel.

Dr. Monroe J. Romansky, Associate Professor of Medicine, George Washington University School of Medicine, was in Richmond, Virginia, October 11 to 15, where he took part in the Postgraduate Course presented by the American College of Physicians. Dr. Romansky participated in a panel discussion and also presented two papers, "Current Trends in Chemotherapy" and "Side Effects of the Antibiotics."

At the Antibiotics Symposium in Washington, October 25–29, Dr. Romansky was moderator of the session on new antibiotics and was co-author of several papers. These papers were entitled:

CHARLES A. HUFNAGEL, M.D.

"Staphylococcal Septicemia and Endocarditis Secondary to Cortisone-treated Exfoliative Dermatitis due to Penicillin," Drs. Lawrence V. Phillips, M. J. Romansky, and John P. Nasou

"Erythromycin: Serum Levels Following Intramuscular Administration," Drs. David S. Davis and M. J. Romansky

CAT

"Treatment of Gonorrhea with Tetracycline (Achromycin) and Carbomycin (Magnamycin)," Drs. G. Roland Gable, M. J. Romansky, and S. Ross Taggart.

Drs. Romansky, Phillips, Nasou, Gable, and Taggart are all Active members of the District Medical Society.

Dr. Murray M. Copeland, Professor of Oncology, Georgetown University School of Medicine, fulfilled a number of out-of-town speaking engagements during the fall months.

As guest speaker at the Schenectady County Medical Society, October 5, Dr. Copeland spoke on "Premalignant Lesions of the Breast." He attended and participated in the Teaching Institute of the Association of the American Medical Colleges and the meeting of the Coördinators of Cancer Teaching in French Lick, Indiana, October 14–18.

At the Centennial Anniversary meeting of the Union Memorial Hospital in Baltimore, Md., November 5 and 6, he read a paper entitled, "An Evaluation of Radical Surgical Procedures for Cancer about the Oral Cavity" and also served on a panel of speakers who discussed "Current Concepts Relative to Carcinoma of the Breast."

He attended the meetings of the Southern Surgical Association in Hollywood, Fla., December 6–10, and presented a paper on "An Evaluation of Neck Dissection Associated with Other Radical Procedures for the Treatment of Cancer in the Head and Neck."

Dr. Roy Hertz, Chief of the Endocrinology Branch of the National Cancer Institute, presented a paper before the Third Pan American Endocrinology Conference in Santiago, Chile, November 21–27. Dr. Hertz described the efforts of research scientists at the National Institutes of Health to shrink cancers by depriving them of the hormones they need for growth.

Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, was guest speaker at the Annual Dinner of the Massachusetts Psychiatric Society in Boston, November 9. His address, historic in content, was entitled, "Psychiatric Vignettes of the Bay State."

Dr. Howard T. Karsner, Research Advisor to the Surgeon General of the Navy, addressed the staff of Crile Veterans Hospital in Cleveland, Ohio, November 23, on "Hemorrhagic Fever."

Dr. Fred L. Soper was reëlected Director of the Pan American Sanitary Bureau at the 14th Pan American Sanitary Conference in Santiago, Chile, in October. Dr. Soper, who is an Associate member of the District Medical Society, became Director of the Bureau in 1947 and was reëlected in 1950. His third term will begin, February 1, 1955.

Dr. George E. Schreiner was the principal speaker at the meeting, October 21, of the Arlington County Medical Society, which was held at the Washington Golf and Country Club. Dr. Schreiner, who is Director of the Renal Service at Georgetown University Hospital, described the use of the artificial kidney.

Dr. Harold Jeghers, Professor of Medicine and Director of the Department of Medicine, Georgetown University School of Medicine, presented an amphitheatre clinic on "Subacute Bacterial Endocarditis" at Boston City Hospital on October 6.

On October 14, Dr. Jeghers participated in the Alumni Day Program at St. Mary's Hospital in Rochester, New York. As clinical discusser in a clinicopathologic conference, he spoke on "Postgraduate Medical Education."

Dr. Walter A. Bloedorn was reëlected Secretary of the Gorgas Memorial Institute of Tropical and Preventive Medicine at its annual meeting, October 29.

Dr. Harry C. Bates, Jr., Arlington, Va., an Associate member of the District Medical Society, **and Dr. Christopher J. Murphy, Jr.,** Alexandria, an Affiliate member, participated in the 1954 Annual Public Relations Conference of The Medical Society of Virginia in Charlottesville, November 18. Dr. Bates, who is Chairman of the Public Relations Committee of the Medical Society of Virginia, was the presiding officer for the afternoon's program and gave a PR Progress Report. Dr. Murphy spoke for Alexandria in a presentation on "How the Forums Work in Virginia."

Dr. Addison M. Duval, Assistant Superintendent of St. Elizabeths Hospital, has been named to the District Commissioners' Youth Council, succeeding

Dr. Zigmond M. Lebensohn, who has resigned from the Council. Dr. Duval has worked closely with the Youth Council's school committee and led in the establishment of the District's first school psychiatric clinic at Anacostia High School.

Dr. C. Herbert Marshall, Jr., of the Federation of Civic Associations, also an Active member of the District Medical Society, was reappointed to the Council by the District Commissioners.

The Washington School of Psychiatry awarded a Diploma in Psychiatry at its 1954 convocation at the Hotel Statler, October 16, to **Dr. Benjamin Jamison,** and a Certificate in Applied Psychiatry to **Dr. Julius Fogel.**

BOOK REVIEW

Practice of Allergy, 3rd ed. WARREN T. VAUGHAN, M.D., Richmond, Virginia. Revised by J. HARVEY BLACK, M.D., Dallas, Texas. Price, $21.00. Pp. 1164. St. Louis: Mosby, 1954.

This is the third edition of the Practice of Allergy. The first was published in 1939. Dr. Warren T. Vaughan was collecting the material for the second edition at the time of his death. It was completed by Dr. Harvey Black and published in 1948. This present edition was revised by Dr. Black and although the format, style, and approach to the subject are retained, it is quite different from the two previous ones; but in this difference, a better text, because controversial aspects of allergy are presented more objectively and impartially.

The sections covering the fundamentals of allergy, as in the previous editions, are excellent. A new chapter on pulmonary function studies by Dr. James Holman has been added and his original chapter on the determination of vital capacity has been retained. The authoritative chapters on pollen counts and surveys have been brought up to date by Mr. Oren C. Durham. Dr. J. B. Howell has made changes in the chapter on fungus allergy and has added a section on the treatment of poison ivy dermatitis. Other additions as the adaptation syndrome of Seyle, collagen diseases, corticotropin and cortisone are brief but adequately covered. The grouping in the Classification of Allergic Diseases (Part XVI) is better than in the previous editions. The discussion of the use of oxygen in the treatment of asthma in the section on Pharmacology is most instructive, stressing that "the administration of oxygen may be a dangerous thing."

A criticism of the previous edition has been corrected with the elimination of statements from the original text as "a *recent*—1936" and "*brought up to date*—1939." The Table of Contents in this edition, however, lists Part XIII and then Part XV, Part XIV having been omitted in number as well as content. Scattered throughout the book are many typographical errors as "thta', for "that."

Most of the photographs are excellent. The detailed charts and tables are instructive. The book is clearly printed and easily read.

This edition is as up to date as any text can be with the rather voluminous current literature on the subject. It is authoritative and can be recommended to all, students and practitioners, interested in the subject as *the* text of our present understanding of Allergy.

ELLIS APRIL, M.D.

BOOKS RECEIVED

Acknowledgment is made of the following books which have recently been received. Selections will be made for more extensive review in the interests of our readers and as space permits. Physicians are urged to submit reviews of additional current books which, in their opinion, merit comment.

Physician in the Courtroom. LESTER ADELSON, M.D., CLINTON DEWITT, LL.B., SAMUEL R. GERBER, LL.B., M.D., AND ALAN R. MORITZ, M.D. Edited, with Introduction and Notes, by OLIVER SCHROEDER, JR., LL.B. Price, $2.00. Pp. 99. Cleveland: The Press of Western Reserve University, 1954.

Urology, Volumes I, II and III. Edited by MEREDITH CAMPBELL, M.S., M.D., F.A.C.S., Emeritus Professor of Urology, New York University. With the Collaboration of Fifty-one Contributing Authorities. Price, $60.00 per set. Pp. 2356, with 1148 figures. Philadelphia: Saunders, 1954.

Review of Medical Microbiology. ERNEST JAWETZ, PH.D., M.D. Professor of Bacteriology and Lecturer in Medicine and Pediatrics, University of California School of Medicine, San Francisco; JOSEPH L. MELNICK, PH.D. Professor of Epidemiology, Yale University School of Medicine, New Haven; AND EDWARD A. ADELBERG, PH.D., Assistant Professor of Bacteriology, University of California, Berkeley. Price, paper, $4.50. Pp. 360. Los Altos, Calif.: Lange Medical Publications, 1954.

Current Concepts in Digitalis Therapy. Bernard Lown, M.D., Formerly Assistant in Medicine, Peter Bent Brigham Hospital, and Samuel A. Levine, M.D., Clinical Professor of Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital. Price, $3.50. Pp. 164. Boston: Little, 1954.

The Role of the Pituitary in Cancer. The Clinical Value of Pituitary Lipid Treatment. Henry K. Wachtel, M.D., Scientific Director of The Chemical Hormone Corporation, 670 Lexington Avenue, New York 22, New York. Price, paper, $2.00. Pp. 31. New York: William-Frederick Press, 1954.

A Ciba Foundation-Symposium: Peripheral Circulation in Man. G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Jessie S. Freeman, M.B., B.S., D.P.H., Editors. Assisted by Joan Etherington. Price, $6.00. Pp. 219, with 72 illustrations. Boston: Little, 1954. **The Kidney.** Arranged jointly with the Renal Association. A. A. G. Lewis, B.Sc., M.D., M.R.C.P., Editor for the Renal Association, and G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., Editor for the Ciba Foundation. Assisted by Joan Etherington. Price, $6.75. Pp. 333, with 125 illustrations. Boston: Little, 1954. **Hypertension: Humoral and Neurogenic Factors.** G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Margaret P. Cameron, M.A., A.B.L.S., Editors. Assisted by Joan Etherington. Price, $6.75. Pp. 294, with 73 illustrations. Boston: Little, 1954. **Leukaemia Research.** G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Margaret P. Cameron, M.A., A.B.L.S., Editors. Assisted by Joan Etherington. Price, $6.75. Pp. 297, with 56 illustrations. Boston: Little, 1954.

JOHN ARTHUR SIMPSON, A.B., M.D.

(1904–1954)

Dr. John A. Simpson, an Active member of the Medical Society of the District of Columbia, died suddenly, October 26, 1954, at his home, 1018 Monroe Street, N.E. His office was in his home.

Dr. Simpson was born in Washington, D. C., December 7, 1904, the son of Arthur Simpson, who survives him, and the late Bridget O'Connell Simpson. He received his early education in the parochial schools of Washington. He was a graduate of Georgetown University, obtaining his Bachelor of Arts degree in 1928 and his medical degree in 1933. After interning at Providence Hospital, he began his practice in the District of Columbia in 1934. He was on the visiting staff of both Providence and Georgetown Hospitals. He taught pathology at Georgetown University for several years in the early 1930's. At the time of his death he was medical director at Catholic University.

Dr. Simpson became a member of the District Medical Society in 1937. He was also a member of the American Medical Association. He was affiliated with St. Anthony's Catholic Church.

In addition to his father, he is survived by his wife, Mrs. Agnes Gannon Simpson; seven children, John, Jr., Robert, Thomas, Michael, Agnes, and Celene, all of the home address, and Anne of the Benedictine Order, Elizabeth, New Jersey; and two sisters, Mrs. Mary Knapp and Miss Ethel Simpson, both of Washington.

RUSSELL KUHNER HOLLINGSWORTH, M.D., M.S.

(1897–1954)

Dr. Russell K. Hollingsworth, thoracic surgeon, who practiced his specialty in Washington for several years at 1835 Eye Street, N.W., died, October 22, 1954, at the San Fernando Valley (California) Veterans Hospital, where he was a member of the hospital staff.

Dr. Hollingsworth was a native Washingtonian, born, March 21, 1897, the son of Sidney P. and Susie Mae Kuhner Hollingsworth. He was educated in public schools and graduated from Central High School. In 1920 he received his medical degree from George Washington University, and the following year interned at Emergency Hospital.

Dr. Hollingsworth began the private practice of medicine in the District of Columbia in 1920. In 1939 he opened the Hollingsworth Clinic at 1418 Good Hope Road, S.E., which he headed for several years. In 1943 he enrolled at the University of Michigan for postgraduate study in thoracic surgery and received the degree of M.S. in Surgery in 1945. Upon returning to Washington he was Chief of Thoracic Surgery at Providence Hospital, and a member of the staff in thoracic surgery at Doctors and Suburban Hospitals. He was consulting thoracic surgeon to St. Elizabeths, Mt. Alto Veterans, and U. S. Naval Hospitals. He was also on the teaching staff of George Washington University as Associate in Surgery, 1945–46.

In 1949 he left Washington to become Chief of Thoracic Surgery at the Newton D. Baker Veterans Hospital in Martinsburg, West Virginia. On July 1 of this year he accepted the position of Chief of Surgery at the Veterans Administration Hospital in San Fernando, California, a 500-bed TB hospital.

Dr. Hollingsworth was an Active member of the District Medical Society from 1922 to 1927 and again from 1937 until 1950, when he transferred to Associate status. He was certified by the American Board of Surgery. He was a Fellow of the American College of Surgeons and a member of the American Medical Association, the American Association for Thoracic Surgery, the American Trudeau Society, the Southern Medical Association, the Washington Academy of Surgery, and the George Washington University Medical Society.

He contributed a number of scientific articles to the literature.

Surviving are his wife, Mrs. Louise B. Hollingsworth; a daughter, Mrs. Jay Jones, of Compton, Calif.; and three sons, Lt. Comdr. Russell K. Hollingsworth, Jr., of San Diego, Calif., Francis Hollingsworth, serving with the Army in California, and Charles Hollingsworth, a student at Virginia Polytechnic Institute, Blacksburg, Va.

SIEGFRIED SPEYER, M.D.

(1887–1954)

Dr. Siegfried Speyer, who practiced obstetrics and gynecology in the District of Columbia before moving to Florida early this year, died suddenly in St. Petersburg, September 28. He lived at 440 Fourteenth Avenue, North.

Dr. Speyer was a native of Germany, born in Michelstadt, August 1, 1887. He graduated from the University of Heidelberg in 1910 and practiced from 1911 to 1936 in Darmstadt and Berlin. A victim of Nazi persecution, he fled from Germany in 1936.

Through the efforts of the late Senator Royal S. Copeland, New York, Dr. Speyer was enabled to secure a license to practice in the District of Columbia by a special Act of Congress in 1938. His offices in Washington were in the Farragut Medical Building.

Dr. Speyer was elected to Active membership in the District Medical Society in 1939.

Surviving are his wife, Mrs. Clara L. Speyer, and two brothers, Maurice and Ernest Speyer, both of Johannesburg, South Africa.

RILEY HENRY GUTHRIE, M.D.

(1895–1954)

Dr. Riley H. Guthrie, formerly an Associate member of the District Medical Society, died, October 23, 1954, at his home, 8205 Moorland Lane, Bethesda, Md. Since 1948 he was consultant to the National Institute of Mental Health.

Dr. Guthrie was born, January 9, 1895, in Smithville, Arkansas, the son of Riley H. and Mary Phillips Guthrie. He received his medical degree from the University of Tennessee in 1921 and his postgraduate training in psychiatry at Boston Psychopathic Hospital.

From 1939 to 1945, Dr. Guthrie was on the staff of St. Elizabeths Hospital as First Assistant Physician. He was also on the staff of Georgetown University as Professor of Clinical Psychiatry. While in Washington he was an Associate member of the Medical Society of the District of Columbia. He resigned his membership when he went to Norwich, Conn., in 1945 to become Superintendent of the Norwich State Hospital. He held this position until 1948, when he moved to Bethesda, Md., where he accepted the post of consultant in the field of mental hospitals to the National Institute of Mental Health. He brought to this position experience gained from 20 years' work in state mental hospitals.

Dr. Guthrie was a diplomate of the American Board of Psychiatry and Neurology. He was a member of the American Medical Association, the American Psychiatric Association, and the New England, Massachusetts and Connecticut Societies of Psychiatry.

He is survived by his wife, Mrs. Mildred W. Guthrie, and two sisters, Mrs. Walter Guerin, of Black Rock, Arkansas, and Mrs. Ruth Paine, of St. Louis, Mo.

CAT.

Self-Induced Abortions—Fuchs and Sites

(*Continued from page 666*)

remaining. Thus the groups of septic abortions rank first as the leading cause of maternal mortality at this hospital.

The predominant instrument being used is the common male urethral catheter which is obtained from a "friend" or "drug store." It is inserted into the uterus after a wire has been passed through it or after having been frozen. Although the catheter is the leading abortifacient in this group, we have seen patients who have resorted to pencils, ice picks, knitting needles, swizzle sticks, douche nozzles, "slippery elm," and digital interference.

The above instruments are seldom sterilized and thus predispose to an overwhelming sepsis. This is characterized by the development of peritonitis, pelvic abscess, toxic hemorrhage, and metastatic abscesses which may occur in the liver, kidneys, brain, and lungs. The incidence of overwhelming sepsis is markedly increased when there is a perforation of the uterus.

SUMMARY

Three groups of abortifacients in self-induced abortion have been discussed: (1) Potassium permanganate, used as tablets or in strong solutions, is responsible for serious bleeding and shock and rarely disturbs the pregnancy (2 cases out of 96); (2) douches (chemicals added) were responsible for 1 maternal death in 3 years; (3) foreign bodies inserted into the uterus, most commonly a urethral catheter, were the leading cause of maternal mortality in the D. C. General Hospital (6 deaths in 3 years).

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